Monitoring, Evidence, Learning and Review (MELR) Montrose FCDO Saving Lives in Sierra Leone (SLiSL)

Endline Review Report

Final version, submitted 3 July 2023

CONTENTS

Credit for front cover picture: Mothers attending a health facility, Sierra Leone ©UNFPA

ABBREVIATIONS

AISPO	Italian Association for Solidarity Among People, INGO
BMGF	Bill & Melinda Gates Foundation
CA	Crown Agents
CAVA	Clinical audio-visual assessments
CCU	Consortium Coordination Unit (UNITE consortium)
CEA	Cost-Effectiveness Analysis
CHAMPS	Child Health and Mortality Prevention Surveillance, INGO
CHC	Community Health Centre
CHW	Community Health Worker
CIP	Costed Implementation Plan
CMO	Chief Medical Officer
COVID-19	Coronavirus Disease 2019
CUAMM	Doctors with Africa
CWW	Concern Worldwide
CYP	Couple Year of Protection (of contraceptive methods)
DALY	Disability Adjusted Life Year
DCM	District Clinical Mentor
DHMT	District Health Management Team
DHIS	District Health Information System
DHS	Demographic and Health Survey
DMO	District Medical Officer
DPPI	Directorate of Policy, Planning, and Information
DRCH	Directorate of Reproductive and Child Health
DQA	Data Quality Audit
DSA	Daily Subsistence Allowance
EMONC	Emergency Obstetric and Newborn Care
EPDs	Ending the Preventable Deaths
EQUALS	Evaluation, Quality Assurance and Learning Service
ETAT	Emergency Triage and Treatment
FGD	Focus Group Discussion
FP	Family Planning
FCDO	Foreign, Commonwealth & Development Office (UK)
FHCI	Free Health Care Initiative
FY	Financial Year
GAVI	The Vaccine Alliance
GESI	Gender Equality and Social Inclusion
GNI	Gross National Income
GoSL	Government of Sierra Leone
HEART	High-Quality Technical Assistance for Results
HMG	His Majesty's Government (UK)
HMIS	Health Management Information Systems
HR	Human Resources
HRH	Human Resources for Health
HSSG	Health Sector Steering Group
INGO	International Non-governmental Organisation
IP	Implementing Partner
IRC	International Rescue Committee
IRMNH	Improving Reproductive Maternal Newborn Health
KSLP	King's Sierra Leone Partnership

KI	Key Informant
KII	Key Informant Interview
LAD	Large Anonymous Donor
LiST	Lives Saved Tool
LLINs	Long-Lasting Insecticide Treated Nets
mCPR	modern Contraceptive Prevalence Rate
M&E	Monitoring and Evaluation
MDSR	Maternal Death Surveillance and Response
MELR	Monitoring, Evidence, Learning, Review
MICS	Multiple Indicator Cluster Surveys
MoHS	Ministry of Health and Sanitation
MSSL	Marie Stopes Sierra Leone
NEMS	National Emergency Medical Services
NGO	Non-Governmental Organisation
NICU	Neonatal Intensive Care Unit
NMSA	National Medical Supplies Agency
ORS	Oral Rehydration Solution
OECD/ DAC	The Organisation for Economic Co-operation and Development/ Development Assistance Committtee
PHU	Peripheral Health Unit
PMI	President's Malaria Initiative
PPFP	Post-partum family planning
PSS	Public Sector Strengthening
PWD	People living with disabilities
QI	Quality Improvement
Q&A	Questions and Answers
QMP	Quality Management Programme
QoC	Quality of Care
RD	Restless Development
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RCPCH	The Royal College of Paediatrics and Child Health-Global Links
SCBU	Special Care Baby Unit
SIDA	Swedish International Development Agency
SLiSL	Saving Lives in Sierra Leone
SRO	Senior Responsible Owner
TA	Technical Assistance
ToC	Theory of Change
ToR	Terms of Reference
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITE	Unite fɔ Sev Layf na Salone consortium
USD	United States Dollar
VfM	Value for Money
WASH	Water, sanitation and hygeine
WHO	World Health Organization
WFP	UN World Food Programme

EXECUTIVE SUMMARY

Background

Sierra Leone has some of the worst maternal and child health indicators in the world.[1] The Foreign Commonwealth and Development Office (FCDO) is investing £170 million through the Saving Lives in Sierra Leone (SLiSL) programme to end the preventable deaths of mothers, new-borns, and children across Sierra Leone, improve access to family planning (FP) especially for adolescent girls and young women and build a more resilient health system that can withstand shocks from health emergencies (*Appendix 1: SLiSL Theory of Change).* SLiSL seeks to save women's and children's lives by improving the quality, availability, and accessibility of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. The programme's purpose is to achieve a sustainable step-change in health outcomes for under-fives, adolescents, pregnant women, and mothers.

The review had three objectives:

1. To verify SLiSL record of achievement as reported through its annual reviews and quarterly and annual reports and defined in the SLiSL Phase 2 and its extensions logical frameworks.
2. To assess the extent to which the SLiSL Phase 2 program performed well and was good value for money, using the six OECD/ DAC review criteria[2]: relevance, effectiveness, efficiency, impact, sustainability, and coherence.
3. To inform the future health programming in Sierra Leone.

Review Methods

Data were collected principally in May 2023 in Sierra Leone[3]. A total of 42 experts took part. A total of four focus group discussions (FGDs) were carried out with 32 clients who had accessed reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. Focus group discussions and individual interviews included: government, implementing partners, funders, International Non-governmental Organisation (INGOs) and patients. Document review, district-level field visits and partner and steering committee coordination meetings provided additional opportunities to meet with SLiSL implementers and observe regular programme coordination and oversight activities. For this review two districts, Bombali and Koinadugu, were included for data gathering. The review in districts was built around an existing quarterly programme joint field visit.

Findings

SLiSL made significant progress against its theory of change and logframe indicators. The programme has consistently scored 'A' ratings in annual reviews, based on achievements of impact and output level results, within the planned budget. Findings emphasised the importance of support across the health system from community to national levels and improved commodities, drug, and blood supplies. SLiSL supported midwifery training and facility level mentoring. SLiSL played a pivotal role in supporting Special Care Baby Units (SCBUs). These were supported at 14 different sites and alongside drugs, commodities and blood required ongoing support. Technical support to the Ministry of Health and Sanitation (MoHS) was widely appreciated. Findings point toward deepening partnership working between partners and with government.

The review findings have significant implications for understanding attributes of RMNCAH: technical and nonmanagement-related for FCDO.

[1] The maternal mortality ratio (MMR) is 717 deaths per 100,000 births (DHS 2019). The neonatal and under-five child mortality rates are 31 and 122 deaths per 1,000 live births, respectively (DHS 2019).

[2] The Organisation for Economic Co-operation and Development/ Development Assistance Committee https://www.oecd.org/dac/review /daccriteriaforevaluatingdevelopmentassistance.htm

[3] One KII took place in June 2023 to accommodate one organisation who were unavailable during May 2023.

The review makes several recommendations; a summary of the recommendations are presented here:

1. **Consolidation** is critical to sustain gains. Support **five key programme components**: i) District-based service delivery through the District Health Management Teams (DHMTs) ii) Quality of care, accountability, and community engagement; iii) Procurement and supply chain management support and iv) Support to data management and information systems and v) Technical support to the MoHS.

2. Protect potentially at-risk areas of the current programme such as the procurement and supply of Free Health Care Initiative (FHCI) commodities and SCBUs. Consolidate and embed support around utilisation, maintenance and planning for medical devices, thus protecting and building on previous investments.

3. Focus on building **phased approaches** to **establishing** and then **sustaining specific programme components with a focus on embedding quality.** For example, incremental government financing for FHCI commodities. Include succession/ transition plans from the beginning that are genuinely owned by government. To support sustainability, continue to promote activities that use existing systems. For example, mentoring run by MoHS mentors, not, Implementing Partner (IP) staff. With greater opportunities for continuous support and accountability this should provide a more sustainable approach to mentoring and support, creating a culture of quality and accountability and embedding this across the health system.

4. Advocate for increased government resource allocations. Conditional co-financing with Government could be used as a means to sustainability and transfer to MoHS of investments at programme end. Support to data management and information systems can help build quality data upon which funding decisions can be made.

5. Improve value for money (VfM) measurement and management by developing a greater shared understanding and framework owned by the implementing partners, facilitated by training to embed a 'culture' of VfM (i.e., using resources in an optimal way to maximise impact) across programme staff and government stakeholders. Useful data for decision-making for both FCDO and the implementing partners should be agreed during the contracting stage. (Further detail on improvements to VfM measurement and management are provided – Appendix 16).

6. **Focus on fewer activities and joint working.** For example, a costed implementation plan is already in place for Family Planning that includes an analysis of why current SLiSL targets for FP were not met[4]. Post-partum family planning (PPFP) was identified as the intervention with the most potential to contribute to Sierra Leone's modern contraceptive prevalence rate (mCPR) growth. FCDO could support implementation of this plan for its focus districts and do this alongside other partners (see Appendix 17 Summary of development partners operating in similar areas to SLiSL)

7. Retain and encourage a programme that is **responsive/ flexible.** Responsive programming could be enhanced through a continued focus on: **systems strengthening;** engagement in and support of long-term **mentoring/coaching approaches** and **quality improvement** initiatives focussed on delivering quality services that are responsive to local needs. Additionally, continuing to develop institutional knowledge built up over time on what is working and identifying programme gaps. SLiSL partners have a deep understanding of the local context and systems, as well as strong partnerships. Using local partnerships and local data will support responsive programming,

[4] MoHS. Sierra Leone Costed Implementation Plan for Family planning 2023-2027. October 2022

although acknowledging poor quality data and working to enhance that should be part of efforts to support responsive programming.

8. Use opportunities of partners meetings, steering committee meetings, and joint field visits more **strategically**. Focus on the RMNCAH continuum of care thinking across the programme alongside delivery against individual logframe indicators. To support this implementing partners meetings and steering committee meetings could be used strategically to review and up-date the programme logic model. Further IPs should be encouraged frequently consider the RMNCAH continuum of care making strategic decisions around gaps in progress and where to focus resources and efforts. For example, a decision to focus on post-partum family planning and focus on outreach targeting marginalised groups and addressing issues of up-take and continued use of family planning. A programme coordination group could be embedded in the MoHS and could help support formation of technical working groups – to increase opportunities for further improvements in coordination.

9. **Continue to create opportunities for synergy and collaboration around programme implementation**: Deepen engagement with other funding partners – strategic level and at the level of implementation e.g., Health NGO partner forum for health implementers, health development partner group for health donors/UN family; the INGO forum; the Health Sector Steering Group (HSSG). The HSSG seems to have become defunct in last two years but could possibly be re-energised in future. Health NGO partners forum and health development partner group could provide good leverage – learning from other programmes and should be focussed on in any successor programmes to leverage programme inputs (Appendix: 17 Summary of development partners operating in Sierra Leone).

1. OVERVIEW OF PROJECT DESIGN FOR SLISL PROGRAMME AND PURPOSE OF THE REVIEW

Sierra Leone has some of the worst maternal and child health indicators in the world.[5] The Foreign Commonwealth and Development Office (FCDO) is investing £170 million through the Saving Lives in Sierra Leone (SLiSL) programme to end the preventable deaths of mothers, new-borns, and children across Sierra Leone, improve access to family planning (FP) especially for adolescent girls and young women and build a more resilient health system that can withstand shocks from health emergencies (*Appendix 1: SLiSL Theory of Change).* SLiSL seeks to save women's and children's lives by improving the quality, availability, and accessibility of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. The programme's purpose is to achieve a sustainable step-change in health outcomes for under-fives, adolescents, pregnant women, and mothers.

Sierra Leone has become a focal country for the United Kingdom's (UK's) renewed manifesto commitment on *'Ending the Preventable Deaths'* (EPDs) of mothers, children, and new-borns[6]. The UK's commitment to EPDs aligns with their priority to strengthen health systems outlined in the 2021 integrated review of security, defence, development, and foreign policy[7]. In conjunction with their health systems strengthening position paper on support Universal Health Coverage (UHC)[8], the EPD approach paper reaffirms the UK's commitment to improve health around the world including in Sierra Leone. The SLiSL programme directly contributes to these goals and has worked to adapt quickly, through repurposing programme funds to support the Government of Sierra Leone's (GoSL) Coronavirus Disease 2019 (COVID-19) response and to maintain essential health services to reduce the impact of the COVID-19 on vulnerable women and children. Two consortia of implementing partners, the United Nations (UN) consortium[9] and the 'Unite fɔ Sev Layf na Salone' Consortium, (UNITE)[10], work together to implement the programme. Support to monitoring, evidence, learning and review (MELR) is provided by Montrose[11]. Technical assistance is provided to the chief medical officer (CMO) to coordinate and drive forward delivery of the National Health Sector Strategic Plans (2017-21 and 2021-2025) and other key Ministry of Health and Sanitation (MoHS) policies and strategies.

SLiSL was originally designed as a five-year programme, 2016 to 2021. The programme comprises two phases (see *Figure 1*), Phase 1 October 2016 to September 2018, and Phase 2, October 2018 to March 2021. Phase 2 was extended until October 2023 (with Montrose MELR involvement due to end June 2023). The extension was designed to ensure continuity in services while successor programmes are designed and procured, a process delayed by COVID-19.

[5] The maternal mortality ratio (MMR) is 717 deaths per 100,000 births (DHS 2019). The neonatal and under-five child mortality rates are 31 and 122 deaths per 1,000 live births, respectively (DHS 2019).
[6] Foreign, Commonwealth and Development Office. (2021). Ending Preventable Deaths of Mothers, Babies and Children by 2030: Approach Paper. December 2021
[7] HMG Cabinet Office. (2021). Policy paper. Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy. July 2021 https://www.gov.uk/government/publications/global-britain-in-a-competitive-age-the-integrated-review-of-security-defence-development-and-foreign-policy/global-britain-in-a-competitive-age-the-integrated-review-of-security-defence-development-and-foreign-policy (Accessed: June 2023)
[8] Foreign, Commonwealth and Development Office. (2021). FCDO Position Paper. Health Systems Strengthening for Global Health Security and Universal Health Coverage. December 2021
[9] The UN Consortium consists of United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO)
[10] The 'Unite fɔ Sev Life na Salone' Consortium is led by the International Rescue Committee (IRC) and includes Doctors with Africa (CUAMM), Restless Development (RD), Concern Worldwide (CWW), Crown Agents (CA), Marie Stopes Sierra Leone (MSSL), GOAL, the Royal College of Paediatrics and Child Health-Global Links (RCPCH), and King's Global Health Partnerships. The Kings Global Health Partnerships working under the name Kings Sierra Leone Partnership (KSLP) component was added to SLiSL in November 2021, to provide critical support to survivors of the Wellington explosion through a training programme for intensive burns treatment.
[11] Montrose is an international development project management and consultancy company headquartered in UK with regional offices in Africa (Uganda) and Asia (Myanmar).

Figure 1: Phases of Saving Lives in Sierra Leone (SLiSL)

The endline review was designed to provide a credible and comprehensive report on the SLiSL phase two programme, in order to directly inform future RMNCAH interventions in the health system in Sierra Leone. The review focuses on Phase 2 achievements, draws on Phase 1 review findings, identifies organisational level lessons and recommendations, and provides specific recommendations for similar future project designs *(Appendix 2: Terms of Reference [ToR])*.

The review had three objectives:

1. To verify SLiSL record of achievement as reported through its annual reviews and quarterly and annual reports and defined in the SLiSL Phase 2 and its extensions logical frameworks.
2. To assess the extent to which the SLiSL Phase 2 program performed well and was good value for money, using the six OECD/ DAC review criteria[12]: relevance, effectiveness, efficiency, impact, sustainability, and coherence.
3. To inform the future health programming in Sierra Leone.

2. METHODOLOGY

2.1. Review Design

A multi-method data collection strategy was used including quantitative and qualitative methods. Quantitative assessment focussed on establishing the programme's achievements against logframe targets and establishing programme effectiveness and impact. Qualitative assessment provided an opportunity for in-depth exploration of the facilitators and barriers to implementing and sustaining RMNCAH health programmes in Sierra Leone and the lessons learned. Data was gathered using document review, key informant interviews (KIIs), focus group discussions (FGDs), district-level joint field visit and partner and steering committee meetings.

Document review supported quantitative assessment of programme achievements and was used to triangulate qualitative review findings. Key informant interviews with experts with unique knowledge of RMNCAH, Quality Improvement (QI) and commodities at national and district levels in Sierra Leone, and SLiSL implementing partners, were used to provide detail about how RMNCAH programmes could be supported from the perspectives of policymakers and those providing services. FGDs were used to gather client perspectives on RMNCAH services. FGDs included pregnant women, lactating mothers, and adolescent males and females accessing family planning.

A district-level joint field visit and implementing partner and steering committee meetings provided opportunities to observe regular programme coordination and oversight activities alongside gathering perspectives of those implementing programmes.

[12] The Organisation for Economic Co-operation and Development/ Development Assistance Committee https://www.oecd.org/dac/review /daccriteriaforevaluatingdevelopmentassistance.htm

SLiSL operates nationwide in Sierra Leone[13]. For this review two districts, Bombali and Koinadugu, were included, for data gathering. Visits to Bombali and Koinadugu were built around an existing quarterly programme joint field visit. These visits and meetings provided opportunities to meet with SLiSL implementers and observe regular programme coordination and oversight activities. Site visits and meetings were held at district management level and in hospitals and one community health clinic. Meetings were held with the (DHMTs in Bombali and Koinadugu. In Bombali district visit were made to Makeni Regional Hospital (providing secondary and tertiary health care) and Kamalo Community Health Centre (CHC), highest level peripheral health unit (PHU)). In Koinadugu District a visit was made to Kabala government hospital, a district hospital providing secondary health care. These visits provided rich opportunities for observations and meetings with district-level implementing partners and community beneficiaries.

The review matrix (*Appendix 3*) outlines the review questions and primary and secondary data sources (qualitative and quantitative). Value for money (VfM) was considered across the review design, data collection, analysis, and findings (*Appendix 4)*. Interview guides for KIIs and FGDs are provided in *Appendix 5*. A separate tool was prepared for summarizing review notes during interviews and the desk-based review (*Appendix 6*). The list of key documents for review is provided in *Appendix 8*.

The review focused on Phase 2 of SLiSL (October 2018 to March 2021) and programme extensions (March 2021 to Oct 2023) and nationwide implementation of the SLiSL programme. It drew on existing review findings of Phase 1 (August 2016 to September 2018).

2.2. Team roles and responsibilities

A core team conducted the review: an external consultant team lead supported by core MELR team members including the MELR VfM experts and MELR technical lead[14] (see *Appendix 7: Team roles and responsibilities*). Management and technical oversight and quality assurance were provided by Montrose.

2.3. Stages of the review

Figure 2 shows the review's three key stages (see *Appendix 2: ToR* for the detailed timeline).

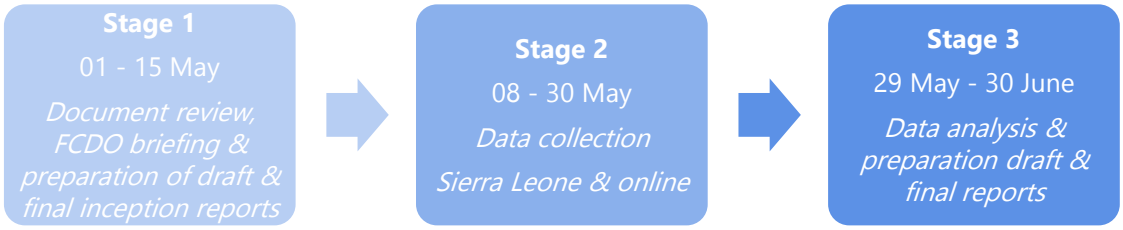


Figure 2: Key Stages of End of Programme Review

Stage 1, inception used document review to identify any priority themes for investigation and categories of key informants and beneficiaries for interview. During this stage, a kick-off meeting with FCDO provided an overview of project implementation experiences and results[15]. This was combined with additional discussions between the Montrose technical lead and VfM experts to prioritise key informants and plan data collection[16].

[13] In all 16 districts of Sierra Leone, although not all activities took place in all districts: Bo, Bombali, Bonthe, Falaba, Moyamba, Kailahun, Kambia, Karene, Kenema, Koinadugu, Kono, Port Loko, Pujehun, Tonkolili, and Western Area Rural and Western Area Urban.

[14] Dr Lynne Elliott – Team Leader; LAMP Development – VfM experts, Dr Heidi Jalloh-Vos – MELR Technical Lead

[15] Held on 10th May 2023 with FCDO, the review Team Leader, VfM expert and MELR Technical Lead Heidi Jalloh-Vos.

[16] Conference calls were held on 01 and 05 May 2023

In stage 2, data gathering (primary and secondary data *see Appendix 3*) primary data were collected from national to community levels (KIIs and FGDs) principally between 10th and 30th May 2023. Only one interview was conducted in late June to accommodate one key informant who was unavailable during May 2023. The majority of data gathering took place during an eight-day visit of the external lead consultant in Sierra Leone and online over a twenty-day period (10th to 30th May 2023). Data gathering began with online interviews with implementing partners (e.g., IRC, UNICEF, WHO). Data collection in Sierra Leone began with the internal SLiSL partners meeting and an initial briefing with FCDO to discuss the review, SLiSL implementation and programme successes and challenges. A meeting with the MELR team at the start of the joint field visit provided an overview of SLiSL and ensured final preparations for data gathering in the field were in place. These meetings were followed by KIIs with SLiSL implementing partners and stakeholders, including GoSL, the joint field visit and focus groups discussions (FGDs) with beneficiary groups. The Sierra Leone visit concluded with a debrief meeting with FCDO and the MELR technical lead to share, discuss, and validate the preliminary findings. Secondary data collection continued alongside primary data gathering, triangulating findings, and establishing the programme's achievements against the theory of change and logframe targets.

Stage 3 focussed on **data analysis and preparation of draft and final reports**. Data analysis followed the themes outlined in the review matrix, triangulating documentary evidence with consolidated site visit notes and interviews. As required in the ToR (*Appendix 2)*, the report synthesises insights for current and future programme planners and funders, drawing out main achievement highlights, learning points, strategic and practical recommendations, and opportunities to consolidate gains made by SLiSL. Preparation of draft and final reports included comments and Q&A with FCDO during a formal presentation of review findings. This presentation was held before the draft report was finalised to ensure FCDO feedback was feed into the draft report. Consolidated comments from FCDO were used to finalise the review report.

2.4. Review participants

The predominant data sources were KIIs with SLiSL implementing partners; experts in RMNCAH, QI and commodities from the GoSL, INGOs and funders (Table 1). A total of 42 experts took part (for detail see *Appendix 9*). A total of four FGDs were carried out with 32 clients who had accessed RMNCAH services (Table 1).

Table 1: Review participants

Sample/ Participant type	Female	Male	Total
Key informant interviews			
National level participants			
Government of Sierra Leone	1	3	4
Funder	3	1	4
INGO	2	2	4
SLiSL implementing partners			
UN consortium	4	8	12
UNITE consortium	5	11	16
Montrose MELR	2		2
Total key informant participants	**17**	**25**	**42**
Focus group discussions			
Community level participants			
Pregnant Women	7		7
Lactating Mothers	8		8
Adolescent family planning service users	9	8	17
Total community level participants	**24**	**8**	**32**
Total No. of KII and FGD participants	**41**	**33**	**74**

Alongside national level KIIs were a district level joint field visit and meetings with DHMT members including district managers, pharmacists, accountants and M&E officers and hospital and primary health care unit staff. Hospital and primary health facility staff included doctors, nurses, and midwives. A list of the joint field visit participants is appended (*Appendix 10).*

All individuals were able to provide information on RMNCAH, and the process of establishing and supporting implementation and embedding these programmes from different institutional perspectives: MoHS (national and district levels), INGOs, SLiSL UN and UNITE implementing partners and donors. This provided adequate diversity within this population and the opportunity to make use of varying perspectives from district and national levels and from various institutional perspectives.

3. KEY FINDINGS

3.1. Relevance

3.1.1. Poor maternal, neonatal, child and adolescent health: the logic for the SLiSL programme

SLiSL was designed in response to identified gaps in the implementation of RMNCAH services[17][18]. Gaps included: high rates of teenage pregnancy, low demand for modern contraception and high unmet needs alongside high rates of maternal, neonatal and under-five mortality, with weak health systems characterised by insufficient drugs, blood supplies and skilled healthcare workforce to provide management and implementation of quality RMNCAH services.

In recent years maternal and childhood deaths have decreased, but indices remain poor[19,20,21.] In 2019, maternal deaths were 717 deaths per 100,000 live births, reduced from 1165 deaths per 100,000 live births in 2013[22]. Despite recent progress however Sierra Leone's maternal mortality ratio remains high (WHO 2019)[23]. Sierra Leone has made some progress towards reducing child mortality, with under-five mortality having reduced from 156 deaths per 1000 live births in 2013 to 122 deaths per 1000 live births in 2019 (Demographic and Health Survey [DHS] 2013 and 2019).

Recent progress has been made towards increasing use of family planning and reductions in adolescent pregnancy. By 2019 the country had achieved 20.9% mCPR among currently married women, and 24% mCPR among all women. This represents a slight change from the 2013 DHS. Adolescent pregnancy reduced from 28% in the SLDHS 2013 to 21% in SLDHS 2019.

SLiSL focussed on addressing these poor health indices impacting women and children in Sierra Leone. The programme built of FCDO's predecessor programme: Improving Reproductive Maternal and Newborn Health (IRMNH) (Figure 3)[24].

SLiSL focussed on five key areas each delivered by different delivery partners (Table 2).

[17] FCDO. 2016. Saving Lives in Sierra Leone. Business Case.
[18] Beattie, Allison and Jalloh-Vos, Heidi. 2018. Break review: Saving Lives in Sierra Leone Programme. March 2018
[19] SL Demographic Health Survey 2013
[20] SL Demographic Health Survey 2019
[21] UNICEF and WHO. 2017. Tracking progress towards universal health coverage for women's, children's and adolescents' health. Countdown to 2030. 2017
[22] SL Demographic Health Survey 2013 and 2019
[23] WHO. 2023. Trends in maternal Mortality 2000 to 2020.
[24] IRMNH was a £25m programme that ran from 2012 to 2016. It aimed to improve awareness and uptake of family planning alongside access to reproductive maternal and newborn health services across Sierra Leone, focusing on young people. IRMNH involved building capacity both in the public and private sectors to deliver a nationwide, comprehensive package of reproductive, maternal, and newborn health care services across Sierra Leone and to increase utilization of services amongst women and young people. It was implemented by UNICEF, UNFPA, MSSL and Options Consultancy.

Table 2: Five key components of SLiSL

Component	Area of Focus	Implementing Partner(s)
1.UN consortium	The UN consortium work predominantly at a national level to strengthen health systems and build capacity. The consortium supports a network of SCBUs across the country, procures free healthcare drugs, conducts health workforce training, and works closely with the government to provide other critical inputs for safe childbirth, neo-natal care, and child nutrition nationally.	UNFPA (lead) WHO UNICEF
2.UNITE consortium	The UNITE consortium works predominantly at district level to support the provision of essential health care, emergency referral services, blood, training, drugs and other critical inputs for safe childbirth, neo-natal care, and child nutrition in 14 of 16 districts in Sierra Leone. Technical assistance (TA) is provided to the Vice President's Office and the National Medical Supply Agency (NMSA) .	International Rescue Committee (lead)
3.Montrose (MELR)	Montrose provide the Monitoring, Evidence, Learning and Review (MELR) function for the programme. Montrose manage and consolidate programme data and evidence to ensure that key lessons and research inform future programming decisions. TA is provided to the Directorate of Policy, Planning and Information (DPPI) and the Directorate of Reproductive and Child Health (DRCH). Medical devices support has also been provided.	Montrose International
4. CMO Technical Assistance (TA)	The TA to the CMO provided support to coordinate and drive forward the delivery of the National Health Sector Strategic Plan (2017-21) and other key Ministry of Health and Sanitation (MoHS) strategies.	HEART / Oxford Policy Management
5.Aftercare for burns survivors	The Kings Global Health Partnerships component was added to SLiSL in November 2021, to provide critical support to survivors of the Wellington fuel truck fire disaster through a training programme for intensive burns treatment.	Kings Global Health Partnerships

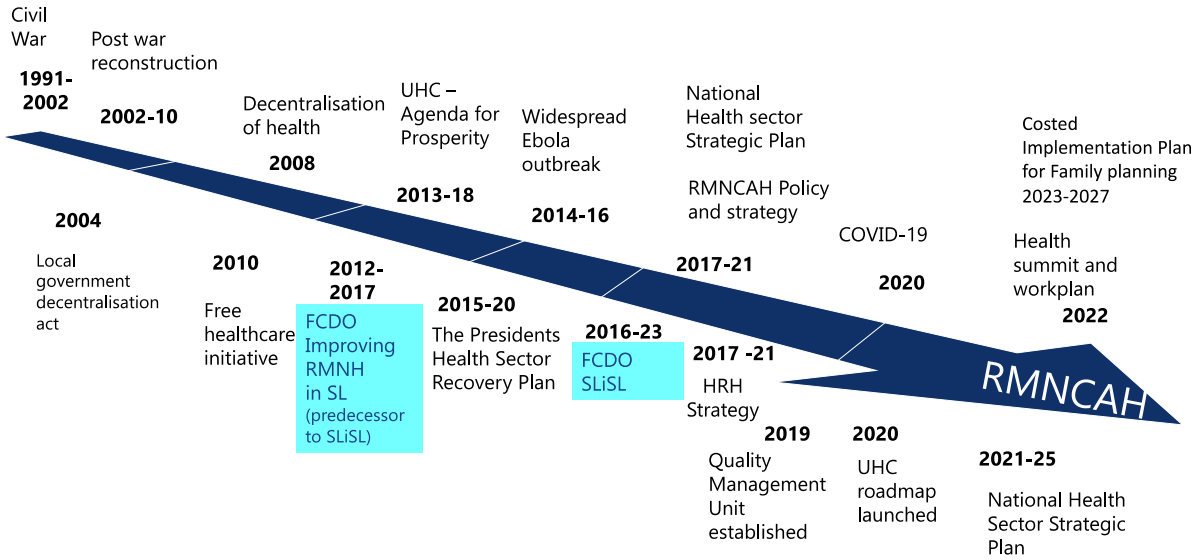
3.1.2. Description of Sierra Leon's policy context for RMNCAH and wider context in Sierra Leone

SLiSL was highly relevant in the context of Sierra Leone and GoSL priorities yet this was a challenging operating context. Having emerged from a period of civil war (1991 – 2002) and post-war reconstruction Sierra Leone has experienced several shocks including a widespread Ebola outbreak (2014-2016) and COVID-19 (2020 – date) (Figure 3). The country's post pandemic recovery was disrupted by concurrent domestic and external shocks exacerbating fiscal vulnerabilities. Inflation and exchange rate depreciation have reached record levels, depressing economic activity, and triggering a severe cost-of-living crisis[25]. Household out-of-pocket expenditure on health care remains high at over 50%[26] yet Sierra Leone is amongst one of the world's poorest countries, with an estimated per capita income of US$480)[27]. In 2020, 52.3% of total healthcare expenditure was out of pocket[28]. Under these circumstances, SLiSL's decision to support free healthcare drugs and take services closer to communities through initiatives such as the special care baby units was highly relevant. In 2011, the proportion of the population spending more than 10% of household income on out-of-pocket health care expenditure was 37% and by 2018 this had reduced to 16% facing catastrophic health care costs[29]. This reduction is possibly in part related to FHCI, and FCDO support to this from the start of SLiSL in 2016.

[25] World Bank Sierra Leone. June 2023. https://www.worldbank.org/en/country/sierraleone/overview#1
[26] Ministry of Health and Sanitation, Republic of Sierra Leone. (2019). National Health Accounts 2019-2020
[27] World Bank (2021). Macroeconomic Context in Sierra Leone. The World Bank https://data.worldbank.org/country/SL)
[28] Ministry of Health and Sanitation, Republic of Sierra Leone. (2019). National Health Accounts 2019-2020
[29] World Bank, Sierra Leone. (2021). The proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%). Available at: https://data.worldbank.org/indicator/SH.UHC.OOPC.10.ZS?locations=SL

Sierra Leone's 2004 post-war decentralization policy provided the framework for decentralisation; a measure taken to ensure that local people and their communities are empowered and fully involved in political and socio-economic development processes[30]. Yet decentralising a healthcare system requires support and takes time to embed, challenges remained. A 2016 review of decentralisation in Sierra Leone demonstrated some of these challenges including: the blurring of delineations of authority between central and subnational government institutions creating three further challenges: a resistance to decentralisation, uncoordinated local-level interventions, and limited accountability for frontline health workers. As part of SLiSL, district-level support to strengthening local services and district health management teams was designed to support decentralisation and strengthen local health systems.

There was no better time for the SLiSL programme with the government's policy and strategy and commitment around free healthcare. RMNCAH remain major policy priorities in Sierra Leone and core to the National Health Sector Strategic Plan (2021-25) and RMNCAH Policy and Strategy (2017-2021). The Free health care initiative (FHCI, 2010) aimed to reduced out-of-pocket payments for health care. FHCI prioritises access to free healthcare for four patient groups: pregnant women, lactating mothers, children under 5 years and Ebola disease survivors. Destitute patients are considered on an informal FHCI group by many facilities. The GoSL has made a strong commitment to UHC in their agenda for prosperity (2013-2018) and in 2020 a UHC roadmap[31]. The programme aligns well with MoHS policy and strategy on RMNCAH (2017[32] and 2022)[33]. In 2018, the GoSL launched the Sierra Leone Social Health Insurance. The law has passed and a pilot for social health insurance is being prepared. With proposals for social health insurance, new costed plans on reproductive health (2022) and a new health strategy (2021) the GoSL has shown its continued commitment to RMNCAH and delivering on UHC and SLiSL was able to support and shape this progress. A good example of this was the need for national support and coordination of quality healthcare across Sierra Leone. With SLiSL support the quality management unit was established at the MoHS in 2019.



[30] World Bank. Srivastava, V. and Larizza M. Decentralisation in Post conflict Sierra Leone: The Genie is out of the bottle. https://documents1.worldbank.org/curated/en/304221468001788072/930107812_201408252042023/additional/634310PUB0Yes0061512B09780821387450.pdf

[31] MOHS launch the Sierra Leone Universal Health Coverage (UHC) Roadmap Commemorating International UHC Day (2020) https://www.google.com/search?q=UHC+road+map+for+sierra+leone&oq=UHC+road+map+for+sierra+leone&aqs=chrome..69i57j0i546.12813j0j7&sourceid=chrome&ie=UTF-8

[32] MoHS. Reproductive, maternal, newborn, child and adolescent health policy and strategy 2017 - 21

[33] MoHS. Sierra Leone Costed Implementation Plan for Family planning 2023-2027. October 2022

Figure 3: SLiSL in the context of Sierra Leone

3.1.3. Operating challenges in Sierra Leone

There have been challenges to operating in Sierra Leone. These include limited improvement in fiscal space within government to fund health care activities or commodities. Healthcare financing in Sierra Leone comes from three main sources – households (52.3%), donors globally (36.2%) and government 16.8%(2020)[34]. Setbacks such as COVID-19 and the continuing recovery from the widespread Ebola outbreak between May 2014 and March 2016 continue to impact on Sierra Leone[35]. Following the Ebola outbreak, the pattern of development assistance to health shifted back from emergency response and humanitarian assistance to recovery and long-term capacity building investments. For SLiSL we heard accounts of expectations among some staff for additional payments for example to take part in mentoring. Additional payments were a system developed during the Ebola outbreak to support MoHS staff.

Sierra Leone's complex social and political context significantly affects programme implementation. The Global Fund for example categorizes Sierra Leone as a "*challenging operating environment*" a designation for countries and regions characterized by weak governance, poor access to health services, and manmade natural crises. The Rule of Law Index[36] placed Sierra Leone 105th out of 140 countries evaluated in its global ranking and 16th out of 34 relative to other countries in sub-Saharan Africa[37]. The index considers adherence to the rule of law and factors such as constraints of government powers, absence of corruption and open government.

3.1.4. The policy and strategy landscape for FCDO

Global health remains a priority for the UK government. A new UK aid strategy, which runs for ten years, was published in May 2022[38]. It has four priorities: reliable investment and trade, empowering women and girls, humanitarian assistance, and climate change, biodiversity, and global health. The new Aid strategy sustains the UK's commitment to Africa.

Alongside UK government commitments to aid have been budget constraints[39]. In 2021, UK aid spending fell 21% compared to 2020 to stand at £11.4 billion. The fall reflected the government's reduction in aid spending from 0.7% to 0.5% of Gross National Income (GNI) in response to the COVID-19 pandemic effects on the UK's public finances and economy. As a result of budget constraints many countries, including Sierra Leone, had reductions in aid in 2021, compared with the amount they had received in 2020. Additional pressure on the UK's reduced aid budget came from the requirement to meet existing commitments to international organizations, increasing humanitarian aid to Afghanistan and Ukraine, and hosting an increased number of refugees and asylum seekers in 2022 and 2023[40].

For SLiSL, these major budget reprioritisation exercises led to three budget reductions. First, an initial limited reduction in Financial Year (FY) 20-21 which brought programme spend broadly in line with previous year's spend at £27m, and then a second more significant reduction for FY 21-22 which reduced the budget to £13m, with the budget remaining approximately at this level in FY 22-23. A third reprioritisation exercise, saw further funding reductions from below £13m to under £10m in FY 22-23.

[34] Ministry of Health and Sanitation, Republic of Sierra Leone. (2019). National Health Accounts 2019-2020
[35] MoHS. The President's Health Sector Recovery plan 2015 to 2020.
[36] World Justice Project, Rule of Law Index, 2022 https://worldjusticeproject.org/rule-of-law-index/global/2022/Sierra%20Leone/
[37] The UK spent £3.7 billion, or 29% of its aid budget, supporting refugees in the UK in 2022.
[38] HMG. (2022). The UK Government's Strategy for International Development. May 2021
[39] House of Commons Library UK Parliament. (2022). Reducing the UK's aid spend in 2021 and 2022. 13 December 2022. Available online: https://commonslibrary.parliament.uk/research-briefings/cbp-9224/
[40] HMG (2023). The UK aid budget and support for refugees in the UK in 2022/23. Research briefing. Thursday, 27 April 2023. Available online: https://commonslibrary.parliament.uk/research-briefings/cbp-9663/

Reprioritisations impacted across the programme but were particularly felt at district service delivery level. An overview of budget reprioritisations and programme adjustments is included in Box 1.

Box 1 – Budget Reprioritisations and the adjustments made to scale and scope of SLiSL

For Unite:

- **2018** Eight implementing partners (IPs) alongside Kings Global Health Partnerships Sierra Leone (KSLP) during COVID-19
- **2021** Extension saw a reduced structure for IPs with three IPs removed including: KSLP, Restless Development (working at community level) and The Royal College of Paediatrics and Child Health (working at facility levels on quality of care)
- Budget reprioritisation meant reductions in the operational support provided to DHMTs including in hard-to-reach riverine communities such as Bonthe, to support with blood supply and oxygen; as well as the discontinuation of the community sensitisation component of the SLiSL programme led by Restless Development.
- **Jan 2023** Crown Agents (CA) removed which saw support to districts around supplies of free healthcare drugs reduced. Three IPs remained: IRC, GOAL and MSSL

Geographic Areas:

- **Dec 2022** SLiSL moved out of 4 districts - the World Bank districts of: Kailahun, Tonkolili, Bonthe and Western Area Rural. The programme then moved out of Pujehun and reduced support to Koinadugu, Bo and Port Loko (all to be part of the USAID programme[41]) which became satellite districts.

Looking ahead, UK Aid spending globally will remain around 0.5% of GNI until at least 2027/28[42]. Other likely budget pressures continue such as the war in Ukraine. As a result, FCDO budget constraints for future work in Sierra Leone, look likely to continue resulting in a reliance on other donors to fill gaps. For example, the next programme will no longer be completely national but focus on only six districts and funding for free health care commodities will be constrained, although national.

In conclusion, the SLISL programme was relevant and remains highly relevant to the priorities and policies for target beneficiaries, national and local partners in Sierra Leone (*Figure 3*). Sierra Leone presents a challenging operating environment and in recent years FCDO have had their challenges with budget constraints. Despite recent improvements in maternal and child health indicators, all gains made through the programme are vulnerable to reversal if financial and other support ceases. Reductions in budget may have had an impact since 2019 results[43].

3.2. Effectiveness – key achievements and progress against logframe

Effectiveness addresses the extent to which programme objectives have been achieved and the anticipated results have been realized. In sum, is the intervention achieving its objectives? This section provides an overview of key achievements and trends, progress against logframe indicators, and reasons for variations from programme targets (with further logframe progress detail provided in Appendix 12). The theory of change (ToC) versions over Phase 2 are provided in Appendix 1.

Since 2016, the SLiSL has achieved significant results against impact, outcome, and output-level targets. Results are addressed in turn, beginning with impact-level targets.

Three out of four (75%) impact targets were met early in 2019, well ahead of their original 2021 endline dates (see *Table 3)*. Targets for reducing neonatal mortality were narrowly missed. Although the

[41] USAID works to maintain access to quality maternal, newborn, child health and voluntary family planning services in Sierra Leone. Available at: https://www.usaid.gov/sierra-leone/global-health

[42] HM Treasury, Government of UK. 2022. Policy paper Autumn Statement 2022. Published 17 November 2022. Available online at: https://www.gov.uk/government/publications/autumn-statement-2022-documents/autumn-statement-2022-html

[43] The pregnancy-related mortality ratio (PRMR) is 796 deaths per 100,000 births (2019). The neonatal and under-five child mortality rates are 31 and 122 deaths per 1,000 live births, respectively (2019).

neonatal mortality rate reduced to 31 per 1,000 live births - in both DHS 2019 and 2021 UN estimates – this remained just over its 29 per 1,000 live births target.

Table 3: Progress SLiSL impact indicators (national surveys and UN estimates)[44]

Impact Indicator	Baseline	Milestone Endline Phase 2	Progress *(CI)*	Progress *(CI, year)*
	2013/2017		2019	2020/21
Maternal Mortality Ratio (MMR) (Maternal deaths per 100,000 live births)	1,165 (2013)	900	**717** *(562-873)*	**443** *(344-587, 2020)*
Neonatal Mortality Rate (Neonatal mortality rate per 1,000 live births)	39 (2013) 20 (2017)	29	**31**	**31** *(23-40, 2021)*
Children under 5 years Mortality Rate (Under 5 mortality rates per 1,000 live births, 0-5 years)	156 (2013) 94 (2017)	125	**122**	**105** *(85-128, 2021)*
Teenage pregnancy proportion: Percentage of 15 - 19-year-olds who have begun childbearing	27.9% (2013) 23.3% (2017)	24%	**21.3%**	Not available

Over Phase 2 there were a total 12 outcome indicators (see *Table 4)* but there were several changes to indicators during this phase. In October 2021 two indicators were discontinued due limited data (Indicator 1.x) and limited scope and data access problems (Indicator 3.x). Outcome indicator 3.xx, (the percentage of children under five sleeping under a treated mosquito net), was dropped in October 2021 following the discontinuation of support for bed nets. However, FCDO's two million long-lasting insecticide treated nets (LLINs), distributed in 2017, did contribute to an increase in the use of nets for children under five (from 49% in 2013 to 59% in 2019; according to DHS data). Outcome indicator 2.3 was moved during Phase 2 from output to outcome level.

Substantial progress has been made against the 12 outcome indicator targets - four (4, 33%, green) met or exceeded expectation, four (4, 33%, orange) did not meet expectation – but were close to their targets and might well be on target if a national survey were held. National surveys, including multiple indicator cluster surveys (MICS) and DHS, were scheduled for 2022 and 2024 but were delayed due to COVID-19 and funding delays. Two (2, 17%) family planning indicators (Outcomes: 2.1 and 2.3) substantially did not meet expectations, while for the remaining two (2, 17%, grey) data was unavailable.

However, some progress was made against targets for women using modern contraceptives (Outcome 2.1). Measured against the current available data (2019 DHS) the percentage of all women using modern contraceptives increased from 20.9% (DHS, 2013) to 23.9% (DHS, 2019). However, the targets for Outcomes 2.1 and 2.3 *(Table 4*) look likely to have been too ambitious even by the standards of the 2018-2022 costed implementation plan (CIP) for family planning. Additionally, recent projections for FP use for women of all ages remains persistently stubborn at just over 20% again underscoring that projected programme targets of 30% and above were set too high and were unlikely to be met[45]. Given recent projections on FP targets and over ambitious targets set for outcomes 2.1 and 2.3 they have been scored orange not red. The current CIP (2023-2027)[46] identifies multiple barriers to reaching the

[44] 2013 and 2019 data from DHS, 2017 data from MICS. UN estimates from IGME (United Nations Inter-agency Group for Child Mortality Estimation) and UN MMEIG (United Nations Maternal Mortality Estimation Inter-Agency Group). Colour coding follows output scoring in FCDO Annual Reviews (ARs) – green = (over)achieved (A, A+, A++), orange = did not meet expectation (B), red = substantially did not meet expectation (C).

[45] FP2030. Track20.Sierra Leone. Available at: https://www.track20.org/Sierra_Leone

[46] Sierra Leone Costed Implementation Plan 2023-2027, Reproductive Health & Family Planning Program, DRCH / MoHS, GoSL, October 2022

ambitious previous CIP targets including: limited MoHS resources, inadequate coordination, lack of alignment of available resources with activities in the CIP, limited data (partner mapping, to visualise intervention scale-up) and significant demand side barriers. Post-partum family planning (PPFP) was identified as the intervention with the most potential to contribute to increasing the modern contraceptive prevalence, as PPFP remains low in Sierra Leone (11.42% at 12 months post-partum). This will be combined with reduction of stockouts and scaling-up long-acting reversible contraceptives (such as implants and Intrauterine Devices (IUDs)) provision via PHUs.

Challenges remain in tracking progress against programme targets. Challenges include: delays in national surveys; changes in how national data is collated and the challenges of attribution each of which have hampered SLiSL's ability to fully track all indicators as planned. For example, for outcome indicator 2.2 (2.2 a. No. of women and girls using modern methods of family planning through FCDO support. 2.2 b. No. of additional women using modern methods of family planning through FCDO support) there have been two main challenges in identifying progress made. First, attribution of family planning efforts supported under FCDO. Second, changes were made to how DHS data was collated during SLiSL implementation. From September 2020, DHS no longer disaggregated data by age and therefore distinguishing FP use for women and girls was no longer available. Given the challenges around data quality there are likely to have been some SLiSL progress made that has been missed due to insufficient data.

Table 4: Progress SLiSL phase 2 current and discontinued outcome indicators[47]

Outcome	Indicator	Baseline *(date)*	Last Ph2 milestone *(date)**	Progress *(date)***
Outcome 1 - Increased use of quality RMNCAH health services, especially by poor women in rural communities	1.1 Percentage of pregnant women including adolescents who receive at least 4 focussed ANC services	76% *(2013)* 77.5% *(2017)*	85% *(Mar 23)*	**78.8%** *(DHS 2019)*
	1.2 Percentage of pregnant women who delivered in a health facility	54% *(2013)* 76.7% *(2017)*	87% *(Mar 23)*	**83.4%** *(DHS 2019)*
	1.x Percentage of all designated EmONC facilities that performed all EmONC signal functions in the last 3 months prior to the survey. *a. BEmONC, b. CEmONC*	a. 13% *(2018)* b. 7% *(2018)*	a.35% b. 23% *(Mar 21)*	**Data not available**
	1.3 Percentage of new-borns who received a PNC visit within 2 days of delivery by CHW or other health provider	27.9% *(2013)* 19.3% *(2017)*	85% *(Mar 23)*	**82.7%** *(DHS 2019)*
Outcome 2 - Increased contraceptive use, especially among adolescents	2.1 Percentage of all women that used modern contraceptive	20.9% *(2013)* 28% *(2017)*	30% / 33% *(Mar 23)*	**23.9%** *(DHS 2019)*
	2.2 a. Number of women & girls using modern methods of family planning through FCDO support. b. Number of additional women using modern methods of family planning through FCDO support	Actuals only		**Data not available**
	2.3 Unmet need for family planning among women 15-49 years	25.0% *(2013)*	10% *(Mar 23)*	**24.8%** *(DHS 2019)*
Outcome 3 - Improved treatment	3.1 Percentage of diarrhoea cases in under-fives treated in community with zinc and ORS	42.7% *(2017)*	60% *(Mar 23)*	**53.4%** *(DHS 2019)*

[47] Baseline data and data against which targets are measured are derived from three main sources: i) 2013 DHS data; ii) 2019 DHS data and iii) 2017 MICS data. Colour coding follows output scoring in FCDO Annual Reviews – green = (over)achieved (A, A+, A++), orange = did not meet expectation (B), red = substantially did not meet expectation (C). *March 2023 milestones are provisional (pending approval by FCDO). **March 2023 progress – no new national survey data after DHS 2019.

Outcome	Indicator	Baseline *(date)*	Last Ph2 milestone *(date)**	Progress *(date)***
and prevention of childhood illnesses	3.x Number and percentage SAM children with medical complication that recovered successfully	89% *(2017)*	90%, 1284 *(Mar 21)*	**94%** *(967 out of 1026), Apr20-Mar21*
	3.2 Percentage of neonates who survived following admission in the NICU and SCBUs, disaggregated by inborn and outborn, male/female and site	80% *(2018)*	85% *(Mar 23)*	**86.9%** *(Jan-Mar 23)*
	3.3 Percentage of children with symptoms of ARI for whom advice or treatment was sought at a health facility or health provider	73.8% *(2017)*	85% *(Mar 23)*	**85.7%** *(DHS 2019)*
	3.xx Percentage of children under five who slept under a treated mosquito net the night before the survey	49% *(2013)*	End phase 1 – 60% Phase 2 – no target	**59.5%** *(2017)* **59.1%** (*2019)*

There were 8 output areas at the start of Phase 2, output 8 was removed early at the request of FCDO considering the large number of indicators and perceived limited usefulness of the related output indicators. The annual review scores by output area (*see Table 5*) reflect the commodity supply constraints affecting output 1. The drop from a score of A to B in output 2 might be related to reduction of resources and FP commodity stock outs. Output 3, 4, 5 and 7 showed consistently good scores. For output 5 the establishment of the national Quality Management Programme (QMP) and increased focus on maternal death surveillance and response (MDSR) were likely catalysts for improving the score from B to A. Output 6 consistently scored A or A+ in annual reviews until 2021. Reductions from A to B scores in 2022 reflects extension budget cuts and ongoing data quality issues, but also design problems of the data quality sub-indicators which aligned to the key dashboard indicators of the MoHS District Health Information System (DHIS)2 data quality tool.

Table 5: Annual Review Scores for SLiSL Phase 2 outputs over time (September 2019 – March 2023)[48]

Output	AR Sept 19	AR Sept 20	AR Sept 21	AR Sept 22	Mar 23 milestone*
Output 1 - Improved efficiency of procurement and supply of FHC drugs and FP commodities and support for nutrition commodities	**B**	**B**	**B**	**B**	**Not available****
Output 2 - Increased demand for and availability of family planning services for adolescents and young people	**B**	**B**	**A**	**A**	**B**
Output 3 - Improved availability of functional hospitals to receive RMNCAH referrals according to standards	**A+**	**A+**	**A**	**A**	**A**
Output 4 - Improved HRH capacity to conduct RMNCAH services	**A**	**A**	**A+**	**A**	**A**
Output 5 - Quality of care framework for RMNCAH services implemented and monitored	**B**	**A**	**A+**	**A**	**A**
Output 6 - Functional DHMTs with increased capacity for district level planning and service	**A**	**A+**	**A**	**B**	**B**

[48] Colour coding follows output scoring in FCDO Annual Reviews (ARs) – green = (over)achieved (A, A+, A++), orange = did not meet expectation (B), red = substantially did not meet expectation (C). *Scored by MELR Montrose review team based on provisional (not approved by FCDO) March 2023 target. **2 indicators no data, 1 indicator stopped.

Output	AR Sept 19	AR Sept 20	AR Sept 21	AR Sept 22	Mar 23 milestone*
delivery for key areas of RMNCAH-supported by strengthened L/HMIS and coordination					
Output 7 - Functional emergencies/disease surveillance, preparedness, and response	**A++**	**A++**	**A+**	**A**	**A**
Output 8 - Programme management guided by learning, sustainability, and Value for Money	**B**				

Beneficiary interviews revealed varied experiences of RMNCAH services reflecting some of the patterns observed in progress against logframe targets. The following beneficiaries spoke enthusiastically of the benefits of good RMNCAH care with staff ready to help and good availability of medicines alongside experiences of limited drugs and expectations of payments among staff.

> *"P7: What is helping us here is easy access (to) the hospital…each time we come to this hospital, there are drugs, and the staff are ready to attend to us. They will conduct tests and prescribe drugs and we return home easily without any delay.*
>
> *P1: What makes it difficult is when you come to the hospital and there are no drugs, it will mean a delay to attend to us. The other thing that makes it difficult is …(sometimes) you cannot go to the hospital completely empty handed; we know medical care is free for the children but if you give a small amount to the nurses, they will attend to you quickly and you will return quickly." Participants were part of a group of lactating mothers who had recently delivered in Koinadugu district.*

When services and drugs were reaching clients, it was clear they were making a positive difference to promoting use of local services.

Table 6 sets out selected key achievements of SLiSL Phase 2 for each of the 7 current output areas, reflecting the engagement of this program in the RMNCAH continuum of care through stages of life (from neonate, child, adolescent, pregnant/lactating women) and health care levels (community, PHUs, district & referral hospitals and connecting ambulance referral services), increasing availability, access, and quality of RMNCAH and wider health care services.

Table 6: Key SLiSL Phase 2 achievements (selected)

Output	Key achievements
Output 1 - Improved efficiency of procurement and supply of FHC drugs and FP commodities and support for nutrition commodities	National Medical Supply Agency (NMSA) established Strengthened health supply chain management resulting in e.g., improved store management, improved supply forecasting and reduced last mile delivery discrepancy rates Supported availability of FHCI/FP/nutrition commodities
Output 2 - Increased demand for and availability of family planning services for adolescents and young people	1,153,027 adolescent 10-19 years accessed family planning services (Oct18-Mar23). Conducted 12,302 RMNCAH community outreach sessions to adolescents/young people
Output 3 - Improved availability of functional hospitals to receive RMNCAH referrals according to standards	36,333 admissions (Oct17-Mar 23) to 14 SCBUs established by the program with good survival rates (88%, 2022) 14 supported district blood banks have minimum quantity of blood available at 95% of the days (Jan-Mar 23) Strengthened coordination of ambulance referral services through support provided to referral coordinators (see short case study example 3: on **Sierra Leone's referral system** in ***Appendix 14***)
Output 4 - Improved HRH capacity to conduct RMNCAH services	Contributed to additional production of 1173 midwives, 91 surgical assistants and 122 nurse anaesthetists.

Output 5 - Quality of care framework for RMNCAH services implemented and monitored	Supported establishment of Quality Management Program and QI processes in the MoHS Improved MDSR processes with improved investigation/review rate from 83% (2017) to 100% (2022), and improved completion of MDSR action points (41%, 2019 to 80%, 2023).
Output 6 - Functional DHMTs with increased capacity for district level planning and service delivery for key areas of RMNCAH-supported by strengthened L/HMIS and coordination	Provision of flexible and operational funds to hospital and DHMTs to maintain key services (also during crises) and respond to emergencies Strengthened district, hospital, and PHU capacities in health care management and key RMNCAH clinical areas (B/C-EmONC, FP, IMNCI, Emergency Triage, assessment, and Treatment (ETAT) through on the job mentoring and trainings
Output 7 - Functional emergencies/disease surveillance, preparedness, and response	Supported ongoing rapid response to emergencies – with 98% responded to within 48 hours (Apr22-Mar23). Improved surveillance data accuracy from 53% (2017) to 86% (2023). Supported IPC with local production of 34,215 litres of alcohol-based hand rub and IPC supervision visits

3.3. Efficiency

Efficiency addresses the extent to which results were delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results. In sum, in considers how well SLiSL resources were used.

3.3.1. Timeliness and budget: achievement of output level results

There is evidence that the output level results were achieved on time and within budget. Good progress has been made against the logframe indicators at output level (*see 3.2 Effectiveness – key achievements and progress against logframe*). Some outputs were subsequently dropped because they had been achieved or activities were no longer funded.

Performance management processes helped achieve targets on time and within budget

The programme had in place systems to manage resources, including quarterly tracking of results and review of activities[49,50]. Regular coordination meetings organised by UNITE consortium coordination unite (CCU), for shared learning and joint problem-solving, were particularly helpful for UNITE IPs to work towards the consortium-level logframe targets. Tracking of value for money unit costs such as cost per couple year protection (CYP) was important for monitoring progress of family planning service delivery (*Figure 4*)

Figure 4: Cost per CYP for UNITE MSSL FP outreach

UNICEF compare costs against outcomes, such as number of lives saved, for the analysis and development of their roadmap for sustainability for SCBUs[51]. There is also evidence that value for money principles have been embedded in programme implementation decisions, for example IPs looked at how to maximise the impact with the resources available, rather than focusing on reducing cost[52]. UNFPA described the use of resource-mapping in family planning to enable decisions based on results and to determine the allocation of resources.

[49] FCDO MELR SLiSL VfM Strategy and Framework, submitted 21 December 2018
[50] KII Senior Staff of NGO
[51] FCDO MELR SLiSL VfM Assessment 2021-2022 submitted 24 March 2023
[52] KII Senior Staff of NGO

It was challenging to achieve some targets, particularly where budgets have reduced
Some targets naturally became harder to meet after budget cuts either stopped or changed activities. In consultation with FCDO the logframe was changed accordingly. Some targets were hard to achieve even before the budget cuts such as implementing MDSR action points within the agreed timeframe. This was a difficult target, particularly within a resource-poor health sector. After budget cuts it became harder for UNITE IPs to conduct activities to support these action points, for example through the provision of some training or mentorship to address an identified gap in knowledge. The UNITE consortium IPs encouraged the use of SMART[53] action points rather than bigger action points that have external dependencies.

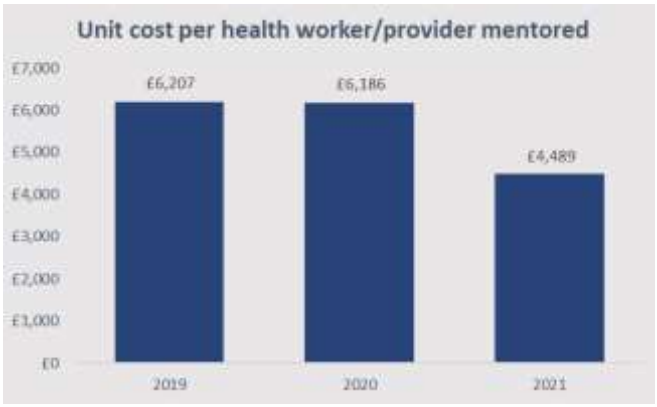
When targets were at risk of being missed, the IPs used alternative strategies where possible. After the exit of Restless Development from the UNITE consortium, Marie Stopes Sierra Leone (MSSL) saw a drop in numbers of clients accessing services[54]. MSSL developed a strategy to embed demand creation within their activities using community health workers (CHWs). This is a lower cost approach, and more sustainable than contracting a third-party organization. However, time is needed to understand the impact of this change on results. Furthermore, CHWs are not a dedicated resource for this activity, and they have competing priorities for their time.

3.3.2. Evidence outputs were achieved in a cost-efficient way

VfM indicators tracked show good performance against trends and benchmarks
The performance of VfM indicators (see Table A in Appendix 11 for graphs) provide evidence that the programme was efficient.

- Administration and management expenditure as a proportion of total programme expenditure has **decreased over time** for the UN consortium. For UNITE, the indicator reduced 24% in 2018/2019 to 20% in 2019/2020. Due to a change in classification of staff costs in the quarterly reports this indicator is not reported for the subsequent years.
- The unit cost per health worker/provider mentored **reduced year on year** between 2019 and 2021 for the UNITE clinical mentorship programme (see *Figure 5*).
- The cost per CYP for Medroxyprogesterone increased between 2019 and 2021 (£2.75 to £2.94) **but reduced to £2.88** in 2022 while the **cost per CYP for levonorgestrel** fluctuated with slight increase from 2019 and 2022 (£2.12 to £2.24)
- The cost per CYP for outreaches **decreased over time** between 2019 and 2021 from £3.31 to £1.64. However, cost per CYP for public sector strengthening (PSS) sites increased from £3.34 in 2019 to £4.74 in 2021, but **still compares well to a benchmark range** (see Table D in Appendix 11)

Figure 5: Unit cost per health worker/provider mentored for UNITE clinical mentorship programme



The VfM indicators within SLiSL's VfM strategy and framework[55] do not cover every output or all the activities conducted under each output but there are some examples (see Table B and C in Appendix 11

[53] SMART - Specific, Measurable, Agreed, Realistic and Time-bound
[54] KII with Senior Staff NGO
[55] Reporting VfM by output was a new requirement from FCDO in 2020. An updated version of the VfM strategy and framework was developed. It was not possible to add new VfM indicators at that stage of the programme.

for list of examples by output) from each output demonstrating approaches and processes in place across the programme to ensure activities and interventions were cost-efficient.

Processes and approaches are in place to ensure outputs are cost-efficient

Procurement processes were in place to ensure inputs are bought for the right price. The implementing partners reported good procurement processes in place[56]. For the procurement of commodities, UNFPA and UNICEF use procurement policies to focus on getting the best quality items at the best possible prices. For example, UNFPA uses a pre-qualification system for suppliers and savings were then reinvested into additional commodities with low stocks[57]. UNFPA and UNICEF use processes that allow for tracking cost, quality, and lead time of procured commodities.

The unit cost of FHCI commodities for dispersible amoxicillin, Magnesium Sulphate, ORS, Zinc Sulphate, reduced between January 2020 and May 2023. However, the unit cost for oxytocin and injectable contraceptive fluctuated during the periods under review while there was a reduction in unit cost between July 2021 - January 2022.

Activities were designed to be efficient, using good coordination and planning by IPs for their own activities as well as across the two consortia. This is demonstrated by the **co-delivery of demand creation and family planning activities** coordinated by RD and MSSL. Training was organised in the most appropriate locations, for example in the districts rather than the central level, in order to reduce travel costs. Where possible, **financial incentives or daily subsistence allowances (DSAs) were avoided.** This strategy was used across the outputs, for demand creation activities for blood donation and family planning as well as for DHMT meetings and varied mentorship and training activities. This was difficult at first due to the engrained use of DSAs within the health sector, but this ultimately set up a cheaper and more sustainable approach in which, for example, mentees were motivated to improve their clinical skills for their own professional development[58].

During the course of implementation, IPs looked for **innovative, different ways to improve efficiency**. The National Medical Supply Agency (NMSA) developed a pilot supported by Crown Agents for a low-cost and efficient model using in-house vehicles for last mile distribution (from district level to health facilities) at 25% of the cost[59]. The substitution of a type of amoxicillin (a first-line antibiotic) for a cheaper and more stable tablet had significant implications regarding transport, storage, and distribution.

The structure of the programme – a long term, multi-year programme, provided IPs with valuable continuity and stability and gave IPs **the opportunity to bring in funds from other shorter-term donors to maximise results.** Both consortiums have examples of this, such as a Large Anonymous Donor (LAD) supported antenatal, post-abortion and other care elements in reproductive health for WHO. This was challenging to report accurately in the quarterly reports and IPs identified the need to better capture this additional benefit created by the programme. The design of the programme, with a presence in every district (n=14)[60] at the beginning of the programme, created opportunities for UNITE consortium to work with partners and make a bigger impact. The Wellbodi Partnership had a small budget for a project improving measurement of blood pressure in mothers, and working with UNITE, leveraged on SLiSL's spread across all districts to increase coverage of this intervention, important for maternal and newborn health.[61]

[56] KII Senior Staff of NGO
[57] FCDO MELR SLiSL VfM Assessment 2021-2022 submitted 24 March 2023
[58] KII Senior Staff of NGO
[59] Value for Money/Cost Efficiency Report, Ex-post analysis using log frame results and actual expenditure in January 2019 to December 2022. Submitted April 2o22)
[60] During the course of SLiSL Phase 2, the number of districts in the country were expanded by GoSL from 14 to 16.
[61] KII Senior Staff of NGO

There were some missed opportunities to make greater efficiencies. SLiSL IPs identified the opportunity to increase efficiency by coordinating supply of commodities from other partners such as Global Fund, e.g., combining distribution of Global Fund commodities and FCDO commodities. This has not yet been possible due to the challenge with timings and the release of funds cycle within Global Fund.

Box 2 - Higher cost does not necessarily mean less value for money. The cost per UNITE clinical mentee in rural areas compared to urban areas is slightly more. The cost per mentee increased on average £14 for every extra kilometre travelled by the mentor from the district centre to a health facility (CHC) highlighting that equity considerations, for example reaching more hard-to-reach groups, can lead to higher costs*.

UNITE also found that overall improvement in clinical skills took a longer time than expected due to the lower baseline clinical competency of mentees. UNITE described the importance of improving skills in this cadre (e.g., State Enrolled Community Health Nurses, MCHAides because they are most likely to treat pregnant mothers at health facilities*.

Cost per CYP for family planning public sector strengthening (PSS) sites mentored by MSSL is higher than for cost per CYP for family planning outreach services. This is because fewer CYPs are generated in the PSS sites due to less skilled health workers in the facilities. However, PSS sites are considered a showcase for UNITE's strategy to ensure ownership and leadership from the government, providing a sustainable model for GoSL in community health centres*.

**Source: Value for Money/Cost Efficiency Report, Ex-post analysis using log frame results and actual expenditure in January*

Attrition of mentees has been an issue for the UNITE clinical mentorship programme, an issue that has efficiency and effectiveness implications. A drop-out analysis by UNITE found that 162 of 405 mentees dropped out before completion, largely (59%) due to mentees being transferred to a non-SLiSL facility[62]. IPs worked with DHMTs to find solutions, including developing non-financial incentives for the district clinical mentors (DCMs) and mentees, and better planning to ensure mentees are not transferred.

Box 3 - Evidence of inputs translating into output level results: WHO provided technical support to the MoHS disease surveillance system, including the e-IDSR which is integrated in the DHIS2. This support has improved the quality of surveillance data reported at the health facility level. The Data Quality Audit (DQA) in November 2022 found that 90.8% of the surveillance data was within ±5% accuracy range (Saving Lives Consolidated Report Q17 (Oct – Dec 2022).

Support to disease surveillance system provides a good example of efficiency, where following initial investment to create the system, it is now being maintained at a low cost (e.g., £6000 per quarter). This involves periodic M&E for implementation of surveillance and audits and data entry at facility level. The electronic surveillance system is not costly because it is automated, a model other countries have shown interest in adopting (KII).

In terms of improving VfM and sustainability, rather than a parallel system to the DHIS2 or a standalone SLiSL system, this system is something the health sector can take up with costs mainstreamed for devices, data server and other costs.

3.3.3. Adaptation to improve efficiency during implementation

There were numerous ways in which the implementing partners adapted and changed their activities in order to develop more efficient ways of conducting the activities with same or improved results. They also adapted to unforeseen changes in circumstances such as COVID-19 and reduced FCDO SLiSL budgets.

[62] FCDO MELR SLiSL VfM Assessment July 2021 – June 2022 submitted 24 March 2023

Creative approaches were used to cope with reduced budgets or COVID-19. The UN consortium used a number of strategies to overcome supply chain challenges caused by COVID-19 such as the ability to leverage on UN sister-organisations like world food program (WFP) to airlift commodities. COVID-19 brought the continuation of a shift from face-to-face to virtual for some activities such as online supportive supervision. Remote clinical audits using clinical audio-visual assessments (CAVA) kept costs low while maintaining clinical quality and are still used by the programme. The reduced budget, and increased costs (due to fuel price increases and increased government DSAs) was mitigated by DHMTs by organising maternal death investigations with fewer individuals. The investigation findings were then reviewed at the DHMT-level among the entire team. PHU in-charges meetings were also used as convenient, lower cost forum for discussing these cases[63].

After SLiSL budget cuts in April 2021, Crown Agents developed a flexible and needs-based approach to the provision of their technical assistance. For example, after the handover of the allocation and quantification processes to (NMSA, they then provided targeted support when needed for those processes. UNITE clinical mentorship adapted to funding cuts while maintaining the same number of mentees. The number of mentors was cut so the remaining mentors adapted by refocusing mentorship topics and redistributing mentors' time across mentees more strategically, identifying mentees who needed greater support. This was enabled by strengthened data monitoring systems which helped plan the distribution of mentors' time across mentees effectively. Mentorship sessions were concentrated on the key Basic Emergency Obstetric and Neonatal Care (BEmONC)topics which was a better fit with the mentees' skill-level[64].

IPs leveraged resources from other donors and partners to cope with budget cuts. This involved enhanced coordination to ensure the programmes enhanced each other. For example, UNFPA coordinated with Islamic Development Bank, resulting in its midwifery programme and scholarships being partly covered by Islamic Development Bank and partly by SLiSL.

Value for Money (VfM) implications

Overall, the performance of the programme against the logframe targets, VfM indicators and FCDO Annual review ratings show that the programme was well managed and efficient. Furthermore, the 2023 review of the impact modelling finds evidence to support the findings of the 2020 impact model. The model demonstrated that the programme was good VfM, saving the lives of women and children at a level of cost that was below the threshold set out in the original business case (2016) of the programme. The IPs also described how they implemented the programme while considering important VfM principles such as focusing on quality and effectiveness, not just looking to reduce costs.

Recommendations to improve the VfM of the programme are covered in the recommendations discussed under the technical attributes of the programme (see section 4.1) and management recommendations (see section 4.2). This includes recommendations related to improving the maintenance and management of medical equipment and devices and improving internal coherence and coordination. It is also important to consider the use of government resources or donor resources on a case-by-case basis to ensure the government capacity i.e., use of CHWs and DHMTs[65], is not overloaded.

During the course of implementation, it was at times challenging to measure VfM and capture the value added by the programme. The VfM framework for SLiSL was developed by Montrose MELR and implemented through a series of annual VfM assessments. Although the VfM framework was developed in consultation with the IPs during a workshop, throughout the course of implementation VfM at times

[63] FCDO MELR SLiSL VfM Assessment July 2021 – June 2022, submitted 24 March 2023; FCDO MELR SLiSL Jan-June 2020 VfM Refresh Assessment submitted 14 September 2020

[64] KII Senior NGO Staff

[65] KIIs with Senior NGO and UN staff stated that CHWs and DHMTs have competing priorities and have a large workload.

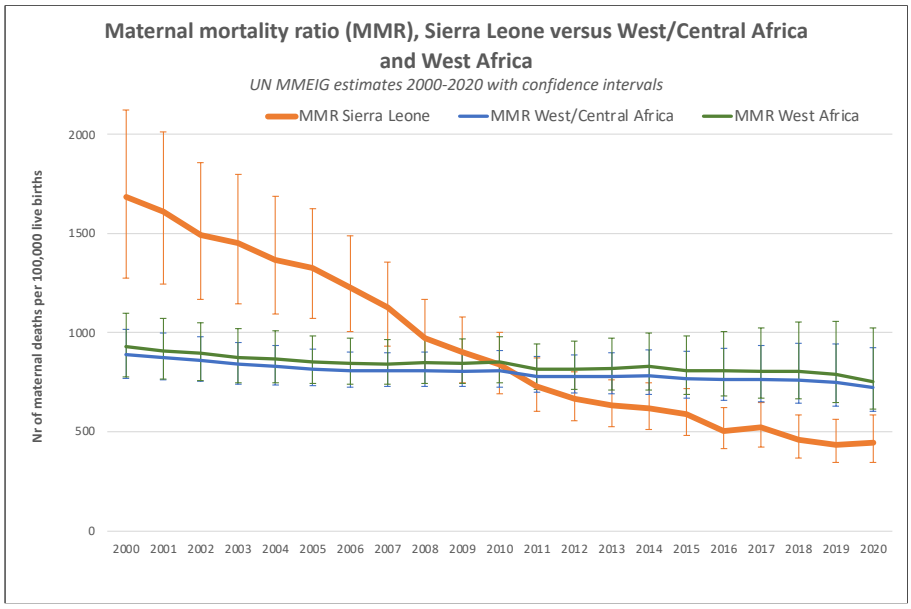
seemed to be more of a monitoring requirement than a framework owned by the IPs. VfM often works best when it is used as a tool to encourage good practice and improve day-to-day decision-making and learning, particularly as not all implementers and staff will have the same level of understanding of VfM. The programme would benefit from early identification of VfM data and indicators that will be most useful to the IPs and to FCDO ensuring that data collection is not a burden but useful and this would help increase ownership of the VfM framework (see Appendix 16 for VfM recommendations).

3.4. Impact

Impact addresses the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the programme, directly or indirectly, intended, or unintended. In sum, impact answers the question – what difference has SLiSL made? Key differences that SLiSL has made include its contribution to: reducing maternal, neonatal and under-five mortality; supporting quality RMNCAH services; reaching marginalised groups and improving blood supplies (3.4.2 and 3.4.3). The section concludes by examining the results of impact modelling conducted as part of this endline review (3.4.4).

3.4.1. Current estimates for maternal, neonatal and under 5 mortality and family planning

Current UN estimates[66] for maternal, neonatal and under 5 mortality, indicate a continued reduction against all three indicators in recent years (*Figure 6).* On all three indicators, the gap between Sierra Leone and other neighbouring countries in West and Central Africa has narrowed. In 2010, the reduction in maternal mortality declined beyond that of neighbouring countries. Given SLiSL is one of the largest donor-supported RMNCAH programmes in Sierra Leone, it is likely that SLISL has made a significant contribution to reductions in maternal, neonatal and under 5 mortality according to current estimates.



[66] Neonatal Mortality Rate and Under 5 mortality rate: UN Inter-agency Group for Child Mortality Estimation, Available at https://childmortality.org/data/Sierra%20Leone. Maternal Mortality: Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division, Available at: https://www.who.int/publications/i/item/9789240068759

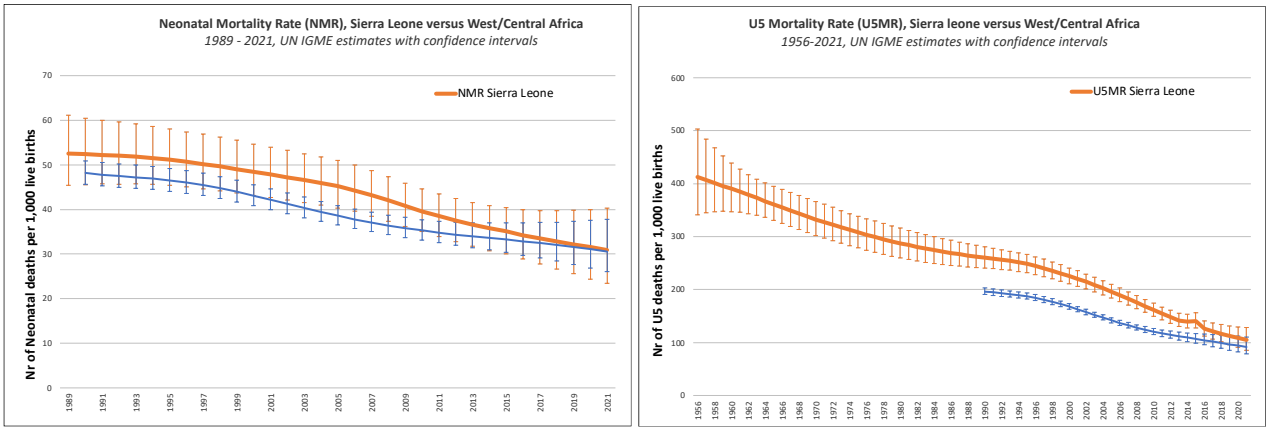


Figure 6: UN estimates for maternal, neonatal and under 5 mortality

3.4.2. Examples of Quality RMNCAH services being established and evidence reaching marginalised groups

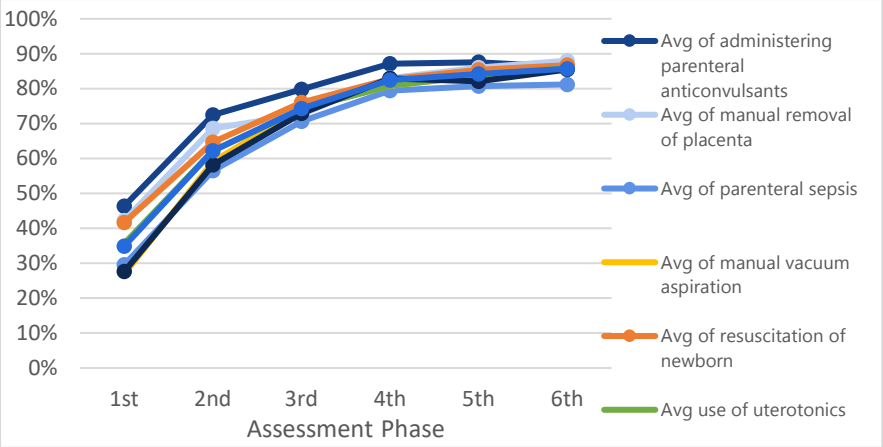
Quality service provision was key to SLiSL programme approach under Output 5: *Quality of care framework for RMNCAH services was implemented and monitored*. With **SLiSL support a dedicated national QMP was established in the MoHS (2019)**. In collaboration with the national QMP, a range of activities were delivered aimed at improving the quality of RMNCAH services. These activities were deemed significant in helping SLiSL achieve impact. For example, MDSR systems were strengthened at district level, district health management teams were supported to conduct MDSRs and practical support such a fuel for vehicles and onsite mentoring were provided. MDSR findings were used to target mentoring and support to address skills gaps for frontline health workers. Key informants equated reduced maternal deaths with trained midwives and other mentorship provided by SLiSL programme to improve clinical competence of health workers. SLiSL supported midwifery training and on-going mentorship to improve quality and accountability for RMNCAH delivery. As part of mentorship, DCMs were trained to provide ongoing support to MoHS staff. Mentoring focussed on using case observations and manikins for practical demonstration of the signal functions. Emergency Obstetric and Neonatal Care (EmONC) mentoring used MoHS staff, typically midwives, as mentors and WHO provided resources for transport to allow MoHS staff to travel to the mentorship sites – an approach that is highly regarded in supporting retention of knowledge and skills after EmONC training; but not always easy to deliver in practice[67].

There was good evidence that onsite mentoring support made a difference to MoHS staff skills and knowledge. For example, most recently, (January to March 2023) 174 mentees received more than 6,270 hours of mentorship. As a result of ongoing mentorship mentee skills and competencies improved steadily across a range of skills (*Figure 7).*

Figure 7: Average Mentee Competency Scores Over Time for All Mentees, by Assessment Phase[68]

[67] Ameh, C.A. (2018). Retention of knowledge and skills after Emergency Obstetric Care training: A multi-country longitudinal study. PloS one. Vol13.Issue 10

[68] Assessment scores are presented as consolidated averages. Note that significantly fewer mentees' assessment scores are included in the 4th, 5th, and 6th assessment phases, as mentee transfers continue to interrupt programme implementation.



There was evidence of spread of SLiSL best practices. Several donors began to consider mentoring, coaching and preceptorship[69]. The USAID funded Momentum programme[70] adopted a mentorship programme focussed on family planning (2019/ 2020) using SLiSL's mentorship framework.

SLiSL's decision to address Sierra Leone's significant skills gaps and in particular the use of **MoHS staff as mentors** was a particularly good example of how SLiSL sought to drive lasting impact by embedding continuous improvement for staff and was often singled out as distinct from previous training.

> *"HR is so critical …. there is a **massive skills gap** in SL…Clinical mentoring meant really looking at retention of skills and **keeping clinical staff on their toes** as part of the programme. This gave a **different flavour** to what the ministry were doing previously. This meant mentoring was quite distinct from simply looking at one-off training courses which government was more familiar with. The mentoring programme promoted **competency checks** on a **regular basis** that were **fair and transparent**…The mentoring model gave the right type of support. Because in the primary health units many of the government staff are not on the government payroll – which means they have very little financial incentive to stay – but mentoring gave an **interesting incentive** for those staff to keep their clinical skills up-to-date and build on them."* - Senior INGO staff member

Highlights of the Emergency Treatment , Assessment, and Triage Plus (ETAT+) programme are described in *Box 4*. The programme was widely credited for its ability to sustain and contribute to: improving skills, motivation and accountability for frontline health workers delivering RMNAH services.

Box 4 – Sustaining HRH for RMNCAH

Emergency Triage, Assessment and Treatment Plus (**ETAT+**) training was implemented by the Royal College of Paediatrics and Child Health-Global Links (RCPCH) and involved 13 Sierra Leonean nurse mentors as national ETAT instructors, paired with international trainers. The mentors were existing MoHS hospital health workers who received no programmatic stipend. ETAT+ was delivered as either an intensive 3 - 4 day short course (mainly for doctors, CHOs and senior nurses), or a facility based 12-week half day a week course (often run in 2 cohorts, so twice a week). The vast majority of those trained were through facility-based long courses. ETAT+ included quality improvement initiatives to improve emergency paediatric care in hospitals. A total of 1,760 mentees had been mentored by March 2021 and 1,002 were assessed as competent in ETAT+[71]. UNITE supported the review of the National ETAT+ training manual and guidelines and the mentorship programme has been absorbed into the government with the establishment of a national ETAT+ working group under the MoHS. The ETAT national mentors trained by RCPCH are still present in hospitals across the country, providing support to the mentees[72].

The mentoring approach that relied on MoHS staff and focused around on-site mentoring was widely praised as having been sustained without SLiSL. **However**, there were some concerns around quality of ongoing support

[69] Preceptorship is a structured start for newly qualified practitioners. The main aim is to welcome and integrate newly registered practitioners into their new team and place of work.
[70] Momentum works to improve overall health and well-being of mothers, children, families, and communities
[71] UNITE Lessons learned from Saving Lives in Sierra Leone programme, April 2022
[72] Key informants for this review; FCDO MELR SLiSL VfM Assessment July 2021-June 2022, Final report submitted 24 March 2023

and the need for a proper oversight. There were concerns that mentorship had not been maintained at the same level in some sites[73] and calls for small amounts of funding to sustain the programme[74]. In the main however, using mentoring delivered at facility level by MoHS, was typically regarded as particularly sustainable.

Further highlights of SLISL's support to HRH development included support to midwifery training. Midwifery faces several challenges in Sierra Leone. Historically, there has been a lack of trained midwives. The total number of midwives recorded at SLiSL's baseline, in 2016, was 325 and in 2018 it was reported that only 500 midwives were working compared to an estimated 3000 required[75]. However, significantly, since this information was collected, SLiSL has trained 1,173 midwives[76] and it is reported that most are in post. Challenges affecting the quality of midwifery training include obstacles such as a lack of consumables and equipment, pervasive negative attitudes of staff towards women seeking medical care[77], and poor collaboration between hospitals and heath training institutions[78]. In light of these challenges the support to midwifery training was regarded as significant in supporting quality RMNCAH. UNFPA's midwifery programme providing support to three midwifery schools Freetown (at Princess Christian Maternity Hospital), Bo and Makeni. Scholarships and stipends were provided to students, in coordination with other donors e.g., when other donors such as Islamic Bank provided tuition fees, UNFPA provided stipends. Other support included resources for faculty members to attain higher education qualifications and resources for MoHS staff to conduct supportive supervision at trainee midwifes' placement sites. UNFPA supported the development of the preceptorship policy and implementation guidelines 2020 by MoHS, a practical guide for midwifery students to use in their placement.

3.4.3. Oversight to sustain and embed good practices

Challenges remain for training and mentoring including limited EmONC equipment at maternity units for mentorship. Key recommendations for strengthening supportive supervision activities included strengthening linkages between the QI mentees and the District Quality of Care focal persons[79] to create a local support network. Once trained, challenges to providing quality care most frequently highlighted by frontline health workers included stock-out of drugs and other commodities at the maternity units, delays in seeking/providing healthcare, and limited ambulance services.

A few IPs spoke of the need for oversight and planning to ensure the **quality** of activities long-term. The requirement for ongoing support does triangulate with research data around quality improvement and mentoring that confirms how challenging it can be to sustain and embed good practices without support[80,81]. Individuals often cautioned there was a bit of variation in terms of how good capacity building for DHMTs had been developed, and some of this depended on the personality of the DMO or other team members. One KI spoke candidly of positive and negatives examples of support to DHMTs

[73] Notes from FCDO Field Visit 2021 referred to in FCDO MELR SLiSL VfM Assessment July 2020-June 2021 submitted 25 October 2021

[74] Key informant for FCDO MELR SLiSL VfM Assessment July 2021-June 2022 submitted 24 March 2023,

[75] Government of Sierra Leone, Ministry of Health and Sanitation. National Nursing and Midwifery Strategic Plan 2019 – 2023. Freetown, Sierra Leone; 2018. https://sierraleone.unfpa.org/en/publications/national-nursing-and-midwifery-strategic-plan-2019-2023. Accessed 3 June 2023

[76] SLiSL Quarter 18, Phase 2 quarterly report - January - March 2023. May 2023

[77] McLellan A, van Ham PT, Sidney D, Aden A, Lacroix A, Edem-Hotah J. Examining person-centred maternal care services at the Princess Christian Maternity Hospital, Freetown, Sierra Leone. African Journal of Midwifery and Women's Health. 2022. https://doi.org/10.12968/ ajmw.2021.0035

[78] Sonnie M, Kella F, Stern A, Mannino CA, Adelman S, Fuller L, Forbush L, Mann J, van de Water B, Falahee B, Sayeed S, Ewing H, Kerry V. A Sierra Leone 2021 Midwifery Clinical Training Needs Assessment: A Call to Action to Augment Clinical Precepting. Annals of Global Health. 2023; 89(1): 10, 1–12. DOI: https://doi.org/10.5334/aogh.3970

[79] SLiSL. 2023. SLiSL Consolidated Quarterly report: Q18: 1 January – 31 March 302

[80] Henriksson, D.K. et al. (2017). Enablers and barriers to evidence based planning in the district health system in Uganda; perceptions of district health managers

[81] Kigume, R. and Maluka, S. (2019). Decentralisation and Health Services Delivery in 4 Districts in Tanzania: How and Why Does the Use of Decision Space Vary Across Districts? International journal of health policy and management. Kerman University of Medical Sciences. Vol 8. Issue 2

needing to be – '*proper capacity building, not the district NGO writing the minutes of the meeting, the government / DHMT officer must be writing the minutes.'* They believed the logframe may incentivise some of that behaviour, *'rather than making sure there was real development.'* More positively they had seen several examples of good practices – 'with *attention to detail in MDSR and in-charges meetings and use of meetings to develop good action points.'* From the field visit the focus on MDSR was working, although there was some evidence of challenges remaining around identifying the reasons behind deaths and fears of blame. For example, one MoHS staff member was at pains to stress a recent maternal death at their facility was due to the timeline of care and the woman being almost deceased before she was delivered to their facility. This is something to tackle in future – focusing on the reasons behind the deaths, rather than blame the timeline of care. Emphasising MDSRs as a mechanism to improve services rather than pinpoint blame may help here.

3.4.4. Support the Free Health Care Initiative: a multi-pronged approach

SLiSL took a multi-pronged approach to improve commodity supply to support free health care; procuring free health care drugs and commodities, contraceptives, and nutrition supplies through the UN consortium and at the same time strengthening the national supply chain system through the UNITE consortium. Included within SLiSL's approach was the agreement for co-financing FHCI commodities with the GoSL and although fiscal challenges reduced the amount the government was able to contribute (e.g., due to COVID-19 response) in reality it was important for encouraging a commitment from government to fund FHCI commodities for RMNCAH beneficiaries (see Appendix 14; Example 1: Free drug supply). A significant issue now is budget management in tough times, especially following COVID-19, and the effects on Sierra Leone's public finances and economy (Section 3.1.2)

SLISL's multi-pronged approach to improving commodity supply was widely credited by MoHS and implementing partners as having made a significant contribution to RMNCAH in Sierra Leone (Appendix 14). For example, given the high amounts spent on out-of-pocket health expenditures and levels of poverty in Sierra Leone SLiSL decision to support free healthcare drugs was relevant and likely to be impacting some of the world's poorest populations[82][83]. As indicted (Section 3.1.2), Sierra Leone witnessed a reduction in catastrophic health care costs (>10% of household consumption or income spent on healthcare) coincident with FHCI commodities being available. The proportion of the population spending more than 10% of household income on out-of-pocket health care expenditure reduced from, from 37% in 2011 to 16% in 2018.

Challenges remain including insufficient commodities. A frequent refrain from stakeholders was the requirement for sufficient supplies of commodities alongside health systems development. A strength of SLiSL's approach was to focus on strengthening systems and providing some supply of essential RMNCAH commodities. Insufficient supplies potentially slowed progress.

> *"…it all boils down to having enough commodities, you get the best systems the best people, but if the commodities are not there then it will not 100% yield the overall impact that we are expecting and on a daily basis, what you are hoping to achieve, to reduce maternal mortality will be limited."* Senior INGO staff member

The field visit helped expose the impact of insufficient medical supplies on service use. During the field visit we heard from PHU staff, providing primary health care, that no drugs often meant no patients or patients being told to bring their own medicines from local pharmacies. From beneficiary interviews availability of medicines was significant in encouraging and promoting use of local services among community members.

[82] Ministry of Health and Sanitation, Republic of Sierra Leone. (2019). National Health Accounts 2019-2020

[83] World Bank, Sierra Leone. (2021). The proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%). Available at: https://data.worldbank.org/indicator/SH.UHC.OOPC.10.ZS?locations=SL

> *"Normally, when we come to the health facility, …they will give us some medicines to take home. I will also… tell others (community members, friends) …I will even show them the medicine they gave me so that, she can be moved to… visit the health facility whenever she is sick or needs medical attention."* Pregnant woman, Karene district.

3.4.5. The success of community outreach

Community outreach was used to provide family planning services, encourage uptake of family planning and support community blood donations. Evidence presented here is supported by a short case study example on the success of community outreach activities in **Appendix 14**.

Outreach is identified as an activity that can provide connection between community members (e.g., adolescents and pregnant women) and health providers and support improved knowledge and attitudes towards family planning alongside opportunities to reach marginalised groups[84,85,86]. Improving easier access to family planning and strengthening field workers' capacity in providing services could help improve access to good quality family planning services[87,88]. Successive costed family planning implementation plans for Sierra Leone (2018-2022 and 2023-27) included outreach activities including initiatives to reach marginalised groups[89,90]. As part of SLiSL, there was good evidence that PSS sites, community outreaches and demand creation activities were successful in supporting marginalised groups including those with disabilities. Client exit interviews in 2020 reported that 6.1% of outreach clients, and 2.3% of PSS site clients were people living with disabilities (PWDs).[91] The national census estimates the PWD population at 1.3%. This suggests that MSSL's efforts to reach PWD clients compares well to the national census benchmark.[92]

Beneficiary interviews reported family planning messages reaching young people in schools. Access to family planning was often linked to increased likelihood for girls completing their education. For mothers family planning meant opportunities to space their children and focus on having fewer children and better supporting those children.

Despite evidence of good progress in reaching vulnerable communities more progress could have been made. The gender equality and social inclusion (GESI) analysis of DHS 2019 data showed inequities for most of the SLiSL Phase 2 impact and outcome indicators, with significant differences between districts, wealth quintiles and education groups. Based on this the desk-based review of 2020 advised a *"Rationalisation of targeting specific areas/groups/individuals/facilities to prevent exclusion and increase equality and equity"* for future programs[93]. This looks set to be useful in shaping future programmes.

Community demand creation activities for family planning and blood donation drives were conducted creating awareness and encouraging stakeholder participation to address social and cultural barriers through effective social behaviour change and communication strategies. Activities used different

[84] WHO. (2016). Recommendations on antenatal care for a positive pregnancy experience.
[85] Mwaikambo, L. et al. (2011). What works in family planning interventions: A systematic review of the evidence. Study of Family Planning. 2011 Jun; 42(2):67-82..
[86] Labat et al. (2018). Contraception determinants in youths of Sierra Leone are largely behavioural. Reproductive Health. 15:66
[87] Keen. S et al. 2017. Scaling up family planning in Sierra Leone: A prospective cost-benefit analysis. Women's Health. 2017, Vol. 13(3) 43-57.
[88] Sserwanja, Q et al. 2023. Determinants of quality contraceptive counselling information among young women in Sierra Leone: insights from the 2019 demographic health survey. BMC Women's Health. 2023.23:266
[89] MoHS. Sierra Leone Costed Implementation Plan for Family planning 2018-2022. 2017
[90] MoHS. Sierra Leone Costed Implementation Plan for Family planning 2023-2027. October 2022
[91] UNITE Learning Event PowerPoint, CCU, 31 January 2022; SLISL Consolidated Quarterly Report, Q13 Oct-Dec 2021
[92] Sierra Leone 2015 Population and Housing Census. Thematic Report on Disability. Francis Kabia & Umaru Tarawally. Statistics Sierra Leone (SSL), October 2017.
[93] Monitoring, Evidence, Learning and Review (MELR), FCDO Saving Lives in Sierra Leone (SLiSL), Desk-Based Review, Version 2, Submitted 4 November 2020 (Final version)

approaches including community outreach, door-to-door sensitization, and engaging community members to reach the most deprived, hard-to-reach communities and vulnerable populations from particularly hard-to-reach areas such as Thambaka chiefdom in Bombali district. When funding for community outreach was reprioritised (FY2022/23) Marie stopes Sierra Leone were able to draw on other donor support for community outreach although SLiSL support was seen as a loss – with activities such as client exit surveys curtailed.

Community blood drives were successfully used to support blood donations in Sierra Leone. In the context of limited funding for blood supplies and support for blood donations SLiSL's decision to include support for blood supplies was considered significant in contributing to reductions in maternal deaths. MDSR investigations point to common concerns around insufficient blood supplies linked to maternal deaths.

> "*…there is very little funding from government (last time I checked the entire program has USD 5,000 – 7,000 allocation from Government including from supplies) and funding going forward will help protect gains made. FCDO has provided massive support for the blood drives. While FCDO may not be able to support it in the way they have done that is a support FCDO should think critically about this support especially since a lot of MDSR investigations revealed that non-availability of safe blood is a big concern for, and in some cases cause of, maternal deaths."* Senior INGO staff member

By 2023 FCDO's SLiSL programme was providing 33% of all blood donations[94]. Given the significant contribution to safe blood supplies in Sierra Leone it is likely that FCDO has made an important impact on reducing maternal death rates.

3.4.6. Review of the 2016-2019 SLiSL impact modelling for the endline review

The mid-term assessment of the SLiSL programme's cost-effectiveness, using the SPECTRUM tool, revealed that £86,222,734 disbursed between 2016 and 2019, potentially **saved the lives of about 24,552 children and 3,188 mothers**. (see *Figure* 8). The **cost per Disability Adjusted Life Year (DALY) averted by the SLISL programme ranges between £81 to £417**, depending on the level of attribution to the programme and **compares well to the business case threshold of £577[95]**.

Figure 8: Lives saved 2016-2019

Since the mid-term impact modelling, a new cost-effectiveness analysis (CEA) has not been conducted by the programme due to lack of DHS survey since 2019, data that is the primary data input of the Lives Saved Tool (LiST) modelling. As a result, a review of the impact modelling (2016-2019) was conducted as part of endline review to determine whether the SLISL programme continues to represent good value for money. The review tested the validity of assumptions in the previous LiST modelling, to determine the extent to which the findings still hold for the period 2020-2022.

The data used for this analysis included the demographic data for intervention areas, United Nations mortality estimates, service utilization data for selected RMNACH services and the programme cost data. The indicators considered were categorized broadly into coverage, quality, equity, and mortality indicators (see Appendix 13 for further detail). A trend analysis of the service utilisation data and

[94] Saving Lives in Sierra Leone. Quarter 18, Phase 2 report (Jan-March 2023). Blood annex. This document confirms the 2022 total for Saving Lives supported blood.

[95] Monitoring, Evidence, Learning and Review of FCDO Saving Lives in Sierra Leone (SLiSL). Economic Evaluation (Cost-Effectiveness Analysis) of the SLiSL Programme for 2020 Annual Review. Submitted: 14 September 2020. Revision: 12 November 2020. Montrose MELR.

mortality estimates was carried out for period 1 (2016-2019) and period 2 (2020-2022) and show that showed that the number of lives saved is likely to have increased for the period 2020-2022.

Table 7: Conceptual framework for impact modelling review

Parameter (Trend)	Comment
Mortality estimate	Not comparable with the DHS data because of difference in methodology
Service utilization	Interpreted along with the population data to understand whether the change in utilization is driven mainly by the population changes or by other factors
Number of Lives saved/DALY averted	Relied on the trend in 1&2 to determine the direction of this parameter.
Programme Implementation cost	This cost is from the perspective of the funder, so it is not economic cost

In conclusion, there is a high likelihood that findings from the 2019 economic evaluation of the programme still hold but this can only be ascertained with a CEA for the period 2020-2022, using new national survey data after 2022. Despite significant funding reductions after the impact modelling time period, the continued impact of the SLiSL programme, and that of other funding partners and government efforts, would have contributed to the improvement in the coverage and quality of health services provided and this is likely to have resulted in a higher number of lives saved. A future CEA would need to consider the appropriate level of attribution that reflects the SLiSL's contribution to the higher number of lives saved.

3.5. Sustainability

Sustainability addresses whether benefits of the programme are likely to continue after donor funding has ceased. There is good evidence that several results will last, although not indefinitely (*Table 8*). Positively there were widespread reports from stakeholders of improved technical competencies amongst MoHS staff to deliver RMNCAH, national policies and guidelines had been developed and management and decision-making capacities at district levels were strengthened. Less positively, a number of activities and results were at risk long-term *(Table 8*). The most frequently mentioned risks included: ongoing support for SCBU's, funding for FHCI commodities, blood supplies, community outreach and supportive supervision. Other activities and commodities that were largely donor-supported were also perceived as being at risk at e.g., fuel for hospital generators. With facilities such as the special care baby units reliant on uninterrupted power supplies insufficient fuel jeopardized continuous quality service provision. Further, given the significant investments in equipment and supplies required for the SCBUs, without support their future was seen to be at risk.

Table 8: Examples of results likely to be sustained and results considered to be at risk

Results that will last, though not indefinitely	At risk
Mentoring approaches especially Emergency Triage, Assessment and Treatment (called ETAT+ or ETAT for short) worked extremely well	Funding for FHCI commodities and special care baby units
Improved capacity of DHMT staff (some DHMTs are stronger than others)	Supportive supervision
DHMTs, and national level staff, will advocate for SLISL activities with other donors. Mentorship is included in ex-SLISL supported district annual work plans *('the will is there').*	District-level activities such as MDSR meetings, in-charges meetings, mobile blood drives

Low cost, low resource activities should continue like MDSR meetings (but see at risk column)		NMSA processes embedded by CA – due to high turnover of staff by NMSA, also, supply chain forum relied on admin support from CA.
Electronic disease surveillance system		Activities that are largely donor-supported e.g., fuel for hospital generators
National policies and guidelines developed		Maintenance of medical equipment and devices including for SCBUs

However, SLiSL took sustainability seriously. An important example of this was the work on SCBU's.

3.5.1. Steps towards improved sustainability in SCBUs

Through SLiSL, UNICEF has established 14 special care baby units (SCBUs) in 14 out of the 16 districts[96]. These hospitals saw a total of 36,333 admissions between October 2017 and March 2023.

UNICEF recognises the SCBUs will not be sustainable without external support for now and they are developing a costed roadmap for sustainability (Box 5).

Box 5 – Special care baby units - creating a sustainable approach - focused on quality improvement and sustainability of the SCBUs. SLiSL support was provided for the equipment maintenance and management policy and subsequently the integrated preventive maintenance and corrective maintenance programme was launched. Training was conducted to build the capacity of technicians and others using an apprentice-style approach (a learning by doing approach). UNICEF are looking to embed progress made to date through a nationwide assessment and inventory of equipment and devices in health facilities, developing information for the computerized management and maintenance system. UNICEF is also consolidating capacity building and training by developing a post-basic certificate in neonatal nursing. Several key informants acknowledged the challenges of sustaining SCBUs – from initial equipment and infrastructure investments to ongoing running costs.

As part of sustainability plans UNICEF are **developing a costed roadmap for sustainability**. Plans include:

- phasing out the international paediatricians and changing their role to regional technical assistance coordinators.
- lobbying for the use of sustainable energy sources such as solar panels. Internal UNICEF resources have been mobilized and work is underway to install solar panels in Kabala hospital and rehabilitate of existing solar panels in Kambia hospital.

To support sustainability, FCDO already has a solar for health project[97] that supports solar panel installation at number of hospitals and potentially at larger CHCs. In addition, oxygen plant and cylinder refill /production with 'hub and spoke'[98] provision, will mitigate the need for continuous electricity for SCBUs and paediatric wards. Although, six oxygen plants have been established in hospitals (from various donors including: FCDO, the Global Fund and Islamic Development Bank), the system is just coming on stream, so is not yet fully tested.

3.5.2. Sustaining Investments in Medical Devices and Facilities

Alongside considerations of the SCBUs are concerns around protecting investments in medical devices and facility rehabilitation. During Phase 1, SLiSL purchased medical devices for PHUs and hospitals to

[96] Establishment of special care baby units (SCBUs) was supported in: Ola During Children's Hospital (ODCH), Bo, Kenema, Makeni, Kono, Pujehun, Moyamba, King Harman, United Brethren of Christ (UBC), Kabala, Magburaka, Kambia, Bonthe Government and Port Loko Hospitals. China Government funded two SCBU's (Kailahun Government Hospital and Sierra Leone Friendship Hospital, Jui).

[97] MoHS and FCDO. Sustainable energy for all – powering hospitals in Sierra Leone. Project Note. The project supports: Ola During Children's and Princess Christian Maternity hospital and Bonthe, Kambia, Kabala and Masanga hospitals. https://www.seforall.org/system/files/2023-04/phc-sierra-leone-hospitals-project-note-v2.pdf

[98] 'Hub and spoke' oxygen provision involves oxygen being generated to fill portable cylinders for more than one health facility in the surrounding area. Dixon, M. (2023). The oxygen concentrator hypothesis – what and how we are learning to strengthen the position of the oxygen concentrator in the global ecosystem. Published in Better Futures CoLab in March 2023. Available at: https://medium.com/better-futures-colab/the-oxygen-concentrator-hypothesis-what-and-how-we-are-learning-to-strengthen-the-position-of-4586f031710e

improve access to quality RMNCAH services. Equipment included items required for general clinical care such as blood pressure machines, laboratory equipment for diagnostics such as microscopes and pipettes, general service items such as sterilizers, and specialized clinical equipment required for reproductive and infant health care such as incubators and infant warmers. Additionally, SLiSL funded the construction or rehabilitation of water, sanitation, and hygiene (WASH) units (e.g., boreholes and pumps) in 237 PHUs during Phase 1. However, from the field visit we saw evidence of unserviceable WASH facilities e.g., Makeni CHC.

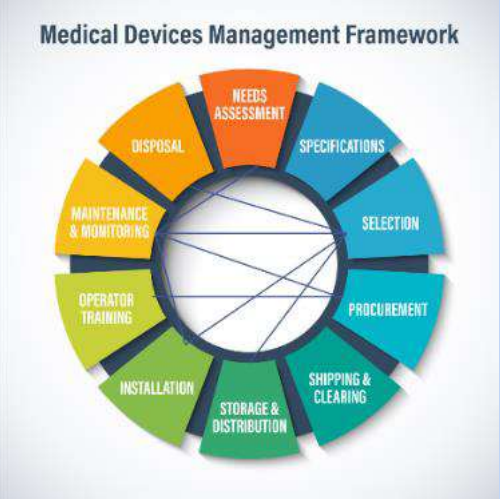
FCDO are keen to protect investments and rehabilitate WASH units where possible using capital funding. As part of protecting its investments and tracking use the SLiSL funded a capital audit in 2020[99]. The audit identified gaps in the maintenance and repair of WASH facilities. For example, 169 facilities had outstanding WASH repairs and 37% of solar powered submersible pumps were out of order. WASH committees, a key part of the original plan for the SLiSL programme, had only been established in 59% of PHUs visited while 35% of the PHUs had an active committee. The audit identified that SLiSL needed to engage the original contractors to review reasons for disrepair in WASH facilities. It recommended collaboration with SLiSL and DHMTs to develop protocols for the maintenance of WASH facilities and further research to understand how to involve the local community with the use and maintenance of the facilities.

The audit found that most of the medical devices provided under SLiSL were in full use. However, devices that were not used at all, or requiring parts and/or maintenance, were present. The audit made some important recommendations on the procurement and management of medical devices and equipment for SLiSL and future programmes. Simple tools were developed for management and decision-making before investments were made (Box 6). These tools look likely to be useful for the SCBUs and across the programme.

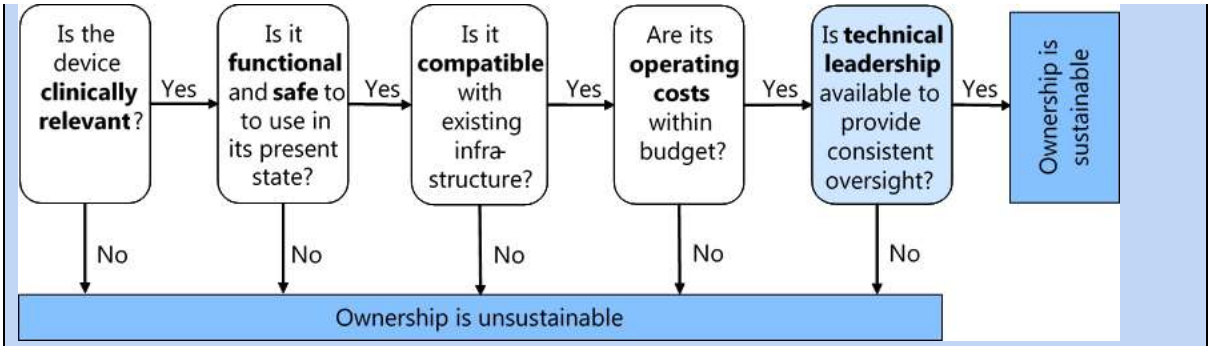
Box 6 – Consolidating investments in medical devices.

Practical tools have been developed under SLiSL to support procurement and management of medical devices and equipment for SLiSL and future programmes. Tools included a medical devices management framework (shown right) and a practical flow chart to support decision-making when acquiring new equipment (shown below). These tools could usefully provide the basis for on-going support to medical planning and management around medical devices.

There were recommendations of training to support to management and planning around medical devices to protect investments. Other practical recommendations included securing manufacturers support when equipment was delivered and installed to ensure equipment was properly used from the outset.



[99] Montrose. (2020). FCDO SLISL MELR Capital Audit: Medical Devices Assessment. Final Report Submitted December 2020



Decision-making flow-chart for medical devices

In summary, SLiSL has taken a number of steps to support ensure the benefits of the programme sustain beyond the life of the programme.

3.5.3. Replicability

Given RMNCAH challenges across Africa and FCDO focus there is positive potential for replication of lessons learned from implementation of SLiSL programme.

The focus on quality RMNCAH services remains highly relevant. Increased use of maternal health services over the past decade has not been matched with reductions in maternal mortality, exposing a crucial deficit in quality of care[100,101]. Often poor-quality services lead to by-passing of local services[102,103]. SLiSL provides 'real world' examples of successes and practical challenges in delivering quality RMNCAH services at scale from national to community levels. SLISL aligns well with recent focus on quality services set out in the SDGs and the global calls for a 'revolution' in quality of health care[104] and to the GoSL and the policy and strategy context in Sierra Leone (Figure 3).

Decentralised health systems and devolved decision-making are especially commonplace in sub-Saharan Africa[105,106]. There is a good deal that can be reflected on against other work with significant opportunities for replicability.

3.6. Coherence and coordination

Coherence and coordination addresses internal and external coherence. It considers the extent to which other interventions (particularly policies) support or undermine the intervention, and vice versa. The extent to which the programme was coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.

3.6.1. Positive perceptions of coherence and coordination

The SLiSL was generally regarded as having good internal and external coherence. Examples of this included:

- **Perceptions of improved national and district coordination.** For example, through UNITE networks lessons and communications could be shared quickly across the country

[100] Kruk et al (2014). Bypassing primary care clinics for childbirth: a cross-sectional study in the Pwani region, United Republic of Tanzania. Bulletin of the World Health Organization. Volume 92. Issue 4
[101] Campbell, J. *et al. (*2016). Evidence for action on improving the maternal and newborn health workforce: The basis for quality care. Int J Gynaecol Obstet. Volume 132, Issue 1.
[102] Kruk et al (2014). Bypassing primary care clinics for childbirth: a cross-sectional study in the Pwani region, United Republic of Tanzania. Bulletin of the World Health Organization. Volume 92. Issue 4
[103] Mubiri, P. (2020). Bypassing or successful referral? A population-based study of reasons why women travel far for childbirth in Eastern Uganda. BMC Pregnancy & Childbirth. BioMed Central. Volume 20. Issue 1
[104] Kruk *et al.* (2018). Putting quality and people at the centre of health systems. Editorial. Lancet Global Health. September 2018.
[105] Eboreime, E.A.N *et al.* (2018). Strengthening decentralized primary healthcare planning in Nigeria using a quality improvement model: how contexts and actors affect implementation. Health Policy and Planning. Vol 33.Issue 6.
[106] McCollum, R. et al (2018). "Sometimes it is difficult for us to stand up and change this": an analysis of power within priority-setting for health following devolution in Kenya. BMC Health Services Research. Vol 18. Issue 1.

- **Positive coordination with MoHS** – through technical working groups.
- **Technical assistance** to GoSL including the Office of the Vice President, NMSA and to the MoHS (CMO office, DPPI, DRCH, on medical devices etc.) was widely appreciated and contributed directly to programme achievements. For example, work on improving the quality MoHS data and advocacy for RMNCAH through the office of the Vice President.
- **Learning was shared** internally within SLiSL but also externally through several learning events held in 2022 to share lessons from SLiSL with partners including government partners (MoHS and the Vice President of Sierra Leone), (I)NGOs and donor organisations. The aim of these events was to disseminate learnings and also advocacy.

As part of this review key learnings from selected SLiSL documents[107] were gathered and synthesized. The three top frequently occurring themes included the importance of focussing on:

- A systems or harmonised approach to activities/objectives to support significant improvements. This can support efficiency including cost savings. Without a focus on systems strengthening, positive change is difficult and, if achieved, is unlikely to last, and wasting of resources is more likely. (28 learning points)
- Due to institutional knowledge built up over time, SLiSL partners have a deep understanding of the local context and systems, as well as strong partnerships, and are able to operate effectively within these. Continuous and specific efforts are required to ensure partnerships are maintained and context knowledge is updated.(21 learning points)
- SLiSL engagement in and support of long-term mentoring/coaching approaches has supported lasting change at the national, district, and local facility level. Additional time and resources used to ensure high quality mentoring has produced better results, as well as learning on "what works" in this approach.(15 learning points).

3.6.2. Negative perceptions of coherence and coordination

Negative perceptions included views among a few government staff of SLiSL being at arm's length from government *"not my data"* or "*coordination meetings are just arranged…and you're told the date*". Further, there were perceptions among some MoHS stakeholders' ideas for research studies and learning were set elsewhere and then learning was shared with MoHS rather taking the decision on what studies should be undertaken. The perceptions of MoHS were usually linked to the funding model and delivery mechanism of SLiSL, through implementing partners.

A challenge to coordination and coherence was limited transparency around donor funding as described by several stakeholders and summed up by one key informant as ***'chaos by design'***. Donors and implementers need to be realistic and focus on negative side of this lack of transparency; it creates opportunities for ***'double dipping and duplication'*.** From government key informants there was recognition of **limited trust of government.**

There was acknowledgement of different funding partners operating in different ways. For example, FCDO channel funds via implementing partners and the global fund channelling funds through government and government being overwhelmed.

One unintended consequence of funds channelled through partners responsible for delivery against a specific logframe indicator was the separation that created for some between RMNCAH activities rather than delivering across a continuum of care (*Appendix 15).* This was addressed in part through steering committee meetings, joint field visits and joint programme delivery. However, a few partners did mention the pressure and focus they at times felt to deliver to their indicator – for example, pressure from the Consortium coordination unit to IPs under the UNITE consortium. The focus on individual

[107] The selected documents were: all specific learning documents from UNITE and Montrose MELR, all joint visit reports and related special reports, all steering and partner committee meeting reports from start of Phase 2 up to and including May 2023.

indicators was evident from the implementing partners meeting attended in Sierra Leone. Whilst a focus on individual accountability is commendable there is more scope for strategic thinking across the programme and the continuum of care for RMNCAH services[108] (*Appendix 15*).

The findings provide rich evidence of the SLiSL programme. Appendix 14 provides additional evidence demonstrating SLiSL's contribution to RMNCAH in Sierra Leone, if you would like to read more. References to appendix 14 have been made across section 3. This is simply a reminder in case the three Appendix 14 with its three short case study examples have been missed.

[108] Kerber et al. (2007). Counting every stillbirth and neonatal death through mortality audit to improve quality of care for every pregnant woman and her baby. BMC Pregnancy Childbirth. 15 Suppl 2.

4. IMPLICATIONS AND RECOMMENDATIONS

An intention for this review was to verify SLiSL's record of achievement; assess the extent to which the SLiSL Phase 2 programme performed well and was good value for money, using the six OECD/ DAC review criteria and provide clear, practical information to inform future health programming in Sierra Leone. Drawing from the findings implications and recommendations are made for technical attributes and management features of successor programmes and for FCDO. The overall purpose of the review was to develop a credible and comprehensive report on the SLiSL phase two programme, in order to directly inform future interventions in the health system in Sierra Leone.

4.1. Implications and recommendations for technical attributes of RMNCAH programmes

The review findings have significant implications for understanding technical attributes of RMNCAH programmes and important implications for future programming. Findings have several practical implications. They suggest multi-level support to **the health system** – **community to national levels**. By way of example – strengthening an efficient commodity supply chain and funding commodities to put through those strengthened systems. Under current circumstances, one without the other would weaken achievements. **Technical aspects of the programme that worked well included** addressing service **quality** and **accountability** – most significantly support to the national **quality management programme**; MDSR and the use of MoHS mentors to provide on-the-job support for frontline health workers. Going forward, **ongoing support** to DHMT planning and to mentees needs to be developed to support and embed new roles. Reflecting further on shared leadership and taking up new roles, was useful to help reflect on these findings. Work from Uganda and Tanzania highlights the challenges of introducing new roles, especially without ongoing support to develop these roles or where providing support was not straightforward to achieve[109,110]. Stimulating **community demand** for services was used to reach groups by creating awareness and encouraging stakeholder participation. However, despite evidence of good progress in reaching communities more could have been done to address equity and reach vulnerable groups[111]. **Protecting and consolidating programme gains going forward is key. Investments in SCBUs and sufficient health commodities** to support the FHCI are currently unlikely to sustain without continued support and these are good examples of where focus needs to remain.

Taken together, these issues form the basis of **four** important recommendations for supporting technical attributes of future RMNCAH programmes.

Box 7: Recommendations for technical attributes of RMNCAH programmes

1. **Consolidation** is critical to sustain gains. Support **five key programme components**: i) District-based service delivery through the DHMTs ii) Quality of care, accountability, and community engagement; iii) Procurement and supply chain management support and iv) Support to data management and information systems and v) Technical support to the MoHS.

   Protect potentially at-risk areas of the current programme such as commodities and SCBU's. Consolidate and embed support around utilisation, maintenance and planning for medical devices, thus protecting and building on previous investments.

[109]Henriksson, D.K. et al. (2017). Enablers and barriers to evidence based planning in the district health system in Uganda; perceptions of district health managers. BMC Health Services Research. Vol 17. Issue 1

[110]Kigume, R. and Maluka, S. (2019). Decentralisation and Health Services Delivery in 4 Districts in Tanzania: How and Why Does the Use of Decision Space Vary Across Districts? International journal of health policy and management. Kerman University of Medical Sciences. Vol 8. Issue 2

[111] Monitoring, Evidence, Learning and Review (MELR), FCDO Saving Lives in Sierra Leone (SLiSL), Desk-Based Review, Version 2, Submitted 4 November 2020 (Final version)

2. Focus on building **phased approaches** to **establishing** and then **sustaining specific programme components with a focus on embedding quality.** For example, incremental government financing to support health commodities. Include succession/ transition plans from the beginning that are genuinely owned by government. To support sustainability, continue to promote activities that use existing systems. For example, mentoring run by MoHS mentors, not IP staff. With greater opportunities for continuous support and accountability this should provide a more sustainable approach to mentoring and support, creating a culture of quality and accountability and embedding this across the health system. The 2023 situational analysis of respectful maternity care in Sierra Leone[112] draws attention to the significance of investing in training and support around respectful maternity care to improve quality service provision. It identifies current weaknesses such as attitudinal barriers among healthcare providers such as disrespect and abuse and weaknesses around implementation and enforcement of respectful maternity care practices – something that ongoing mentoring and support looks set to address.

   With a focus on health systems strengthening and embedding good practices it is acknowledged that this can take time e.g., supporting to DHMTs and QI teams to embed quality across the health systems. Continue to support DHMTs and QI teams and build team members as they consider new roles in relation to existing work and, once established, support teams undertaking new roles, and then sustain roles. Plans should continually take account of the absorptive capacity of MoHS staff and opportunities to rationalise work with other donors. For example, many partners such as Global Fund have a health systems strengthening component. Activities would be streamlined with other partner plans.

3. Advocate for increased government resource allocations. Conditional co-financing with Government could be used as a means to sustainability and transfer to MoHS of investments at programme end. Support to data management and information systems can help build quality data upon which funding decisions can be made.

4. **Focus on fewer activities and joint working.** For example, a costed implementation plan is already in place for Family Planning that includes an analysis of why current SLiSL targets for FP were not met. Post-partum family planning (PPFP) was identified as the intervention with the most potential to contribute to Sierra Leone's mCPR growth. FCDO could support implementation of this plan for its focus districts and alongside other partners.

4.2. Implications and recommendations for management of RMNCAH programmes

The review has important implications for understanding management of any successor RMNCAH programme. The **flexibility** of SLiSL meant it was able to respond to health challenges and incidents as these arose. The response to the Wellington fuel truck fire disaster through a training programme for intensive burns treatment was a good example of this.

SLiSL has made significant progress in achieving logframe targets. However, focussing across the programme and the **RMNCAH continuum of care** is equally important to a focus on individual indicators. Attention has been paid to thinking across the programme, but IPs should be encouraged to do this more frequently, making strategic decisions around gaps in progress and where to focus resources and efforts. For example, a decision to focus on post-partum family planning and focus on outreach targeting marginalised groups and addressing issues of up-take and continued use of family planning.

Decentralisation in Sierra Leone began in 2004, yet challenges remain. There were accounts of weak and underfunded subnational systems persisting. At the same time, at national level with multiple funding partners supporting the MoH the scope and scale of donor support was not always clear. Further,

[112] Montrose. MELR of FCDO's SLiSL programme. Respectful Maternity Care in Sierra Leone – Situational Analysis. June 2023

programme ownership was for some MoHS staff exacerbated with arms–length funding arrangements through implementing partners – more common among national-level partners.

Overall, the performance of the programme against the logframe targets, VfM indicators and FCDO Annual review ratings show that the programme was well managed and efficient. Embedding a culture of VfM remains critical for SLiSL and any new successor programme.

Taken together, these issues form the basis for **four** important recommendations for supporting technical attributes of RMNCAH programmes.

Box 8: Recommendations for management of RMNCAH programmes

1. Retain and encourage a programme that is **responsive/ flexible**. Responsive programming could be enhanced through a continued focus on: **systems strengthening;** engagement in and support of long-term **mentoring/coaching approaches** and **quality improvement** initiatives focussed on delivering quality services that are responsive to local needs. Additionally, continuing to develop institutional knowledge built up over time on what is working and identifying programme gaps. SLiSL partners have a deep understanding of the local context and systems, as well as strong partnerships. Using local partnerships and local data will support responsive programming, although acknowledging poor quality data and working to enhance that should be part of efforts to support responsive programming.

2. Use opportunities of implementing partners meetings, steering committee meetings, and joint field visits more **strategically**. Focus on the RMNCAH continuum of care thinking across the programme alongside delivery against individual logframe indicators. To support this implementing partners meetings and steering committee meetings could be used strategically to review and up-date the programme logic model. A programme coordination group could be embedded in the MoHS and could help support formation of technical working groups – to increase opportunities for further improvements in coordination.

3. **Focus on increasing coherence at subnational levels** – link to other sectors education, agriculture (nutrition - overlooked). At local levels work with local government councils. For example, supportive supervisions to PHUs could involve local government to promote deeper understanding of health system. As local level engagement increases links to education and other sectors should become easier and can be used to expand support for local health initiatives.

4. Improve value for money (VfM) measurement and management by developing a greater shared understanding and framework owned by the implementing partners, facilitated by training to embed a 'culture' of VfM (i.e., using resources in an optimal way to maximise impact) across programme staff and government stakeholders. Useful data for decision-making for both FCDO and the implementing partners should be agreed during the contracting stage. (Further detail on improvements to VfM measurement and management are provided – Appendix 16).

4.3. Implications and recommendations for FCDO

Clear communications with FCDO were appreciated – for example, around FCDO budget reductions.

Synergies and collaboration were important. Deepening engagement with other funding partners at strategic levels and at the level of implementation. With multiple funding partners supporting MoHS there was often limited transparency around donor funding - described by one KI as ***'chaos by design'*** **creating opportunities for** ***'double dipping and duplication'***. From government stakeholders there was recognition too of limited trust of government. Opportunities to increase transparency, enhance trust and recognition could enhance synergy between donor funding – for the benefit of communities

across Sierra Leone. A programme theory, depicted in a logic model, that maps out the inputs, activities, and expected outcomes in the context of Sierra Leone could be developed collaboratively by implementers and policymakers. Developing a logic model collaboratively, could support a good understanding and planning across the programme. Additionally, implementing partners meetings and steering committee meetings could be used strategically to review and up-date the programme logic model and continue to promote strategic planning and management across the programme.

Box 9: Recommendations for FCDO

1. **Use joint planning opportunities** to bring policy makers and practitioners together to build a programme logic model to support strategic thinking across the programme.
2. **Continue to advocate for sustainable budgeting** which means commodities, support to blood supplies etc become an integral part of annual plans and budgets. Meantime use phased approaches to donor support to increase government support annually.
3. **Continue to create opportunities for synergy and collaboration around programme implementation**: Deepen engagement with other funding partners – strategic level and at level of implementation e.g., Health NGO partner forum for health implementers, Health Development Partner group for health donors/UN family; the INGO forum; the Health Sector Steering Group (HSSG). The HSSG seems to have become defunct in last two years but could possibly be re-energised in future. Health NGO partners forum and Health Development Partner Group could provide good leverage – learning from other programmes and should be focussed on in any successor programmes to leverage programme inputs (Appendix: 17 Summary of Development partners operating in Sierra Leone).

4.4. Conclusion

In conclusion, this review found implementation of the SLiSL programme was highly relevant and valued. Insights presented throughout the review were summarised around the key review objectives *(Appendix 2: ToR):*

1. To verify SLiSL record of achievement as reported through its annual reviews and quarterly and annual reports and defined in the SLiSL Phase 2 and its extensions logical frameworks.
2. To assess the extent to which the SLiSL Phase 2 program performed well and was good value for money, using the six OECD/ DAC review criteria[113]: relevance, effectiveness, efficiency, impact, sustainability, and coherence.
3. To inform the future health programming in Sierra Leone.

SLiSL has consistently performed well against the programme's logical frameworks. For government and IPs navigating programme implementation, multiple factors contributed towards better support for RMNACH services:

There was recognition that:

- national and district level focus was a good way to reinforce results and support sustainability.
- a focus in driving quality at national and local levels could help embed a culture of quality improvement
- attention was still required to support essential free health commodities and plan for the future of SCBU's
- although community outreach had been deprioritised this year any new programme should include this component with a special focus on reaching the most vulnerable groups.

[113] https://www.oecd.org/dac/review /daccriteriaforevaluatingdevelopmentassistance.htm

- Technical support of any successor programme should continue for the MoHS
- Management of any successor programme should include greater emphasis on approaches to keep MoHS leading the programme at district and national levels.

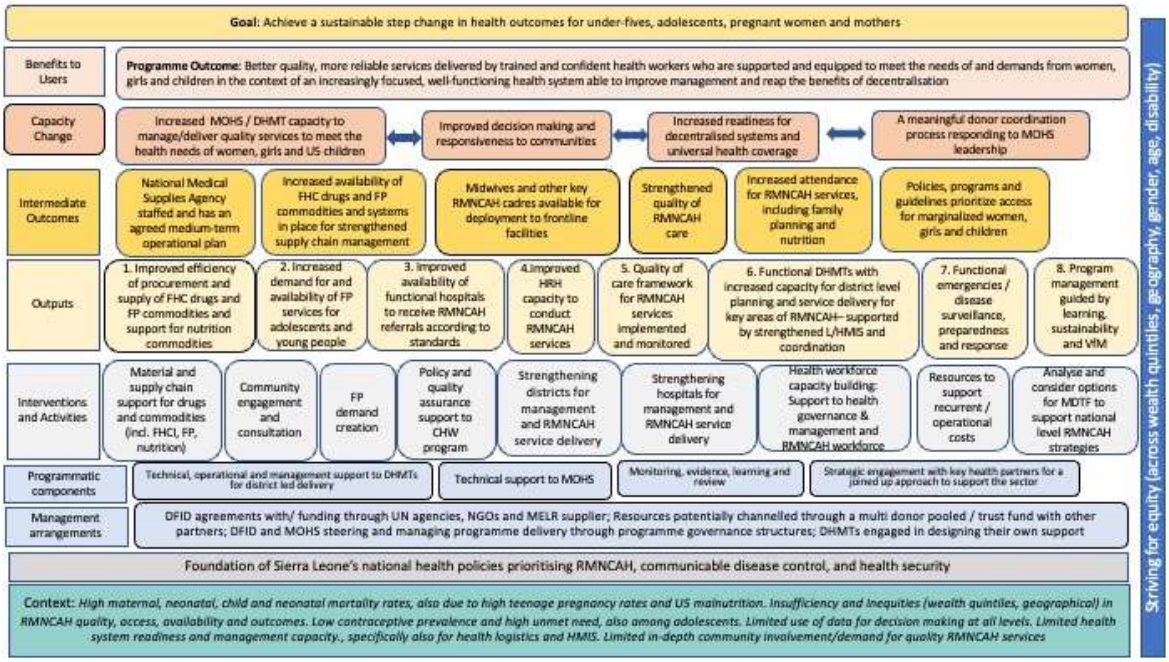
Poor maternal, child, neonatal and adolescent health indicators provide the rationale for a continued focus on RMNCAH in Sierra Leone. Recent calls for a '*revolution*' in the quality of health services and a strong interest in improving systems to support universal health coverage by expanding access to services provide further rationale for continued support. The review provides a timely contribution to how future programmes might continue to support a range of activities including RMNCAH; contribute to improving UHC and enhancing accountability of health service providers to deliver quality health services. Continuing to work from community to national levels building strong delivery at each level and grounding work in quality service provision, could offer a potential framework to consolidate work already underway in embedding responsive, quality UHC and RMNCAH services in Sierra Leone.

5. APPENDICES

Appendix 1: Theory of change

There are two (2) theory of change (ToC) versions for SLiSL Phase 2: a. The original ToC of December 2018 and b. The revised ToC of June 2021. Both versions are displayed below.

Theory of Change with assumptions – December 2018

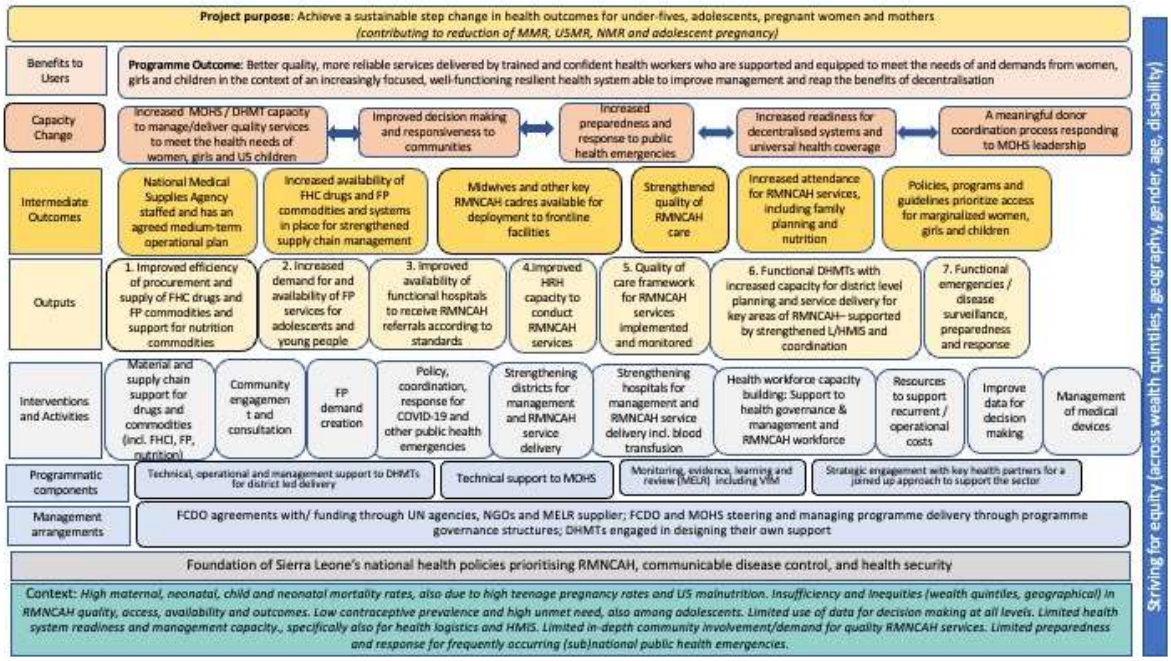


Level	Assumptions
Impact	• Increasing contraceptive prevalence reduces the frequency of pregnancy and hence the frequency of risk of a maternal death. • Delaying first birth reduces the number of the most risky pregnancies • Improved quality and access to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services including improved Emergency Obstetric and Newborn Care (EmONC), delivered at scale improves the chance of a safe delivery and enables better management of maternal and neonatal risk • Reduced prevalence of childhood illness, better availability of treatment and services to save newborn lives reduces child mortality • Different methodological approaches to be used to measure success might not have significant difference in estimating impact • Ongoing support to blood service by other donors (covering all other sites beyond Centres of Excellence) throughout the project period • Ongoing support of World Bank to National Emergency Medical Services (NEMS) throughout the SLiSL project period • Ongoing support of DFID to Marie Stopes Sierra Leone (MSSL) for family planning activities not covered under the SLiSL project (under another DFID project) • Ongoing support of DFID for the SABI project (accountability)
Outcome	• Improved data quality and use; accountability; equitable deployment of human resources; and quality improvement processes lead to better quality services and improves community trust in services. • Community learning and action leads to shifted norms related to acceptance of contraceptives and overcomes barriers to safe delivery leading to increased Contraceptive Prevalence Rate (CPR), reduced teenage pregnancy and improved service utilisation • WASH interventions lead to improved hygiene and reduced childhood illnesses
Output 1	• Government laws and regulation remain the same on importation of family planning commodities, drugs and related supplies. • UN agencies and Government of Sierra Leone (GoSL) will procure the necessary medicines and commodities in sufficient amounts and on time. • Continued buy-in from GoSL and partners for the establishment and continuation of National Medical Supplies Agency (NMSA) • Sufficient distribution support to DDMS/NMSA by MOHS/Partners after stopping of NGO consortium distribution support in June 2020
Output 2	• Communities are willing to participate in outreach days and community sensitisation activities • Adolescents and young people will adopt healthy behaviours based on improved knowledge

Level	Assumptions
Output 3	• Strong leadership from Ministry of Health and Sanitation (MoHS) strengthen the referral and safe blood services • National ambulance service continues to function as planned (NEMS) • Children continue to benefit from the national ambulance service • Change in behaviour of people to donate blood improved the supply chain of blood • Capacity to make minor maintenance of equipment's at MoHS improved • Improved road network to facilitate effective referral • Ambulances are not used for non-health emergencies • Referrals are accurately documented at health facilities • Necessary equipment and materials are available to be procured • Communities are receptive towards sensitisation to become blood donors
Output 4	• Strong leadership from MoHS and Ministry of Education (MoE) in increasing enabling environment for education and learning in nursing and midwifery schools facilitate quality of education • Strong commitment of MoHS in respecting national standards, procedures and regulations • Tutors are motivated to provide quality educations
Output 5	• Sufficient leadership and governance by MoHS improve quality management • Analysis of service delivery data drives use of flexible funds in the learning districts, • Supportive supervision overcomes barriers in performance of regional and tertiary hospitals • Strong collaboration between the UN consortium and NGO consortium, • NGO consortium strictly use nationally endorsed guideline, manual, Standard Operating Procedures (SOP's), tools etc., • NGO's support to District Health Management Team (DHMT) does not substitute DHMT and facility level operation and management works, • NGO consortium report learning to MOHS with strong accountability • HRH issues that seriously affect Quality of Care (QoC) will be progressively resolved • Strong collaboration, participation of other directorates including sector ministries will be enhanced

Level	Assumptions
Output 6	• Sufficient leadership from national MoHS initiate change processes in the DHMT • Strong collaboration and coordination between the UN and NGO consortium • Enhanced accountability of MoHS and DHMT on reporting • Infrastructure like internet continue to be accessible by the DHMT • National MoHS committed to share database of Human Resource Information System (HRIS) for Districts and other directorates • PHUs (Peripheral Health Units) have a mechanism for submitting HMIS reports to DHMTs • Monthly and quarterly meetings are conducted as scheduled • PHUs maintain or increase the number of staffs per facility. • Data including maternal death reviews are available
Output 7	• Sufficient leadership from national MoHS initiate strengthen the surveillance and outbreak response system • Strong collaboration and coordination between the UN and NGO consortium • Enhanced accountability of MoHS and DHMT on reporting • Infrastructure like internet continue to be accessible by the DHMT
Output 8	• Collaboration of GoSL/MoHS and main health sector donors / funders

Theory of Change with assumptions – June 2021



Level	Assumptions
Impact	• Increasing contraceptive prevalence reduces the frequency of pregnancy and hence the frequency of risk of a maternal death. • Delaying first birth reduces the number of the most risky pregnancies • Improved quality and access to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services including improved Emergency Obstetric and Newborn Care (EmONC), delivered at scale improves the chance of a safe delivery and enables better management of maternal and neonatal risk • Reduced prevalence of childhood illness, better availability of treatment and services to save newborn lives reduces child mortality • Different methodological approaches to be used to measure success might not have significant difference in estimating impact • Ongoing support to blood service by other donors throughout the project period • Ongoing support of World Bank to National Emergency Medical Services (NEMS) throughout the SLiSL project period • Ongoing support to family planning services by other donors throughout the project period • Ongoing support of FCDO for the SABI project (accountability) • COVID-19 impacts last for at least one year and recovery lasts for at least another half year • Collaboration of GoSL/MoHS and main health sector donors / funders to continue to support COVID-19 (and other public health emergencies) response and recovery • Increasing multisectoral engagement for RMNCAH
Outcome	• Improved data quality and use; accountability; equitable deployment of human resources; and quality improvement processes lead to better quality services and improves community trust in services. • Community learning and action leads to shifted norms related to acceptance of contraceptives and overcomes barriers to safe delivery leading to increased Contraceptive Prevalence Rate (CPR), reduced teenage pregnancy and improved service utilisation • WASH interventions lead to improved hygiene and reduced childhood illnesses

Level	Assumptions
Output 1	• Government laws and regulation remain the same on importation of family planning commodities, drugs and related supplies. • UN agencies and Government of Sierra Leone (GoSL) will procure the necessary medicines and commodities in sufficient amounts and on time. • Continued buy-in from GoSL and partners for the establishment and continuation of National Medical Supplies Agency (NMSA), including reliable resource allocation and disbursement for NMSA operations • Procurement of FP supplies in 2020 is sufficient for the entire extension period (12 months implementation Apr 2021– March 2022 and 6 months transition April-September 2022)
Output 2	• Communities are willing to participate in outreach days and community sensitisation activities • Adolescents and young people will adopt healthy behaviours based on improved knowledge
Output 3	• Strong leadership from Ministry of Health and Sanitation (MoHS) strengthen the referral and safe blood services • National ambulance service continues to function • Children continue to benefit from the national ambulance service • Change in behaviour of people to donate blood improved the supply chain of blood • Capacity to make minor maintenance of equipment's at MoHS improved • Improved road network to facilitate effective referral • Ambulances are not used for non-health emergencies • Referrals are accurately documented at health facilities • Necessary equipment and materials are available to be procured • Communities are receptive towards sensitisation to become blood donors • Blood drives and collection can continue to take place during health emergencies
Output 4	• Strong leadership from MoHS and Ministry of Education (MoE) in increasing enabling environment for education and learning in nursing and midwifery schools facilitate quality of education • Strong commitment of MoHS in respecting national standards, procedures and regulations • Tutors are motivated to provide quality educations

Level	Assumptions
Output 5	• Sufficient leadership and governance by MoHS improve quality management • Analysis of service delivery data drives use of flexible funds in the learning districts, • Supportive supervision overcomes barriers in performance of regional and tertiary hospitals • Strong collaboration between the UN consortium and NGO consortium, • NGO consortium strictly use nationally endorsed guideline, manual, Standard Operating Procedures (SOP's), tools etc., • NGO's support to District Health Management Team (DHMT) does not substitute DHMT and facility level operation and management works, • NGO consortium report learning to MOHS with strong accountability • HRH issues that seriously affect Quality of Care (QoC) will be progressively resolved • Strong collaboration, participation of other directorates including sector ministries will be enhanced
Output 6	• Sufficient leadership from national MoHS initiate change processes in the DHMT • Strong collaboration and coordination between the UN and NGO consortium • Enhanced accountability of MoHS and DHMT on reporting • Infrastructure like internet continue to be accessible by the DHMT • National MoHS committed to share database of Human Resource Information System (HRIS) for Districts and other directorates • PHUs (Peripheral Health Units) have a mechanism for submitting HMIS reports to DHMTs • Monthly and quarterly meetings are conducted as scheduled • PHUs maintain or increase the number of staffs per facility. • Data including maternal death reviews are available
Output 7	• Sufficient leadership from national MoHS initiate strengthen the surveillance and outbreak response system • Strong collaboration and coordination between the UN and NGO consortium • Enhanced accountability of MoHS and DHMT on reporting • Infrastructure like internet continue to be accessible by the DHMT

Appendix 2: Terms of Reference

Terms of Reference for Endline review of Saving Lives in Sierra Leone Programme

Montrose is an international development project management and consultancy company providing support to clients operating in the developing world. Specialised in the sectors of health, education, rural livelihoods and private sector development, our clients include bilateral and multilateral development agencies, the private sector, Non-Governmental Organisations, and other development stakeholders.

Background

Montrose has been contracted to support the Monitoring, Evidence, Learning and Review (MELR) of the FCDO Saving lives in Sierra Leone (SLiSL) programme. SLiSL seeks to save women's and children's lives by improving the quality, availability, and accessibility of reproductive, maternal, newborn and child health services. The programme's purpose is to achieve a sustainable step-change in health outcomes for under-fives, adolescents, pregnant women, and mothers. The five-year programme is divided into two phases: Phase 1 is from October 2016 to September 2018, and Phase 2, from October 2018 to March 2021.

Saving Lives in Sierra Leone (SLiSL) works to end the preventable deaths of mothers, children, and new-born across Sierra Leone, while improving access to family planning and building a more resilient health system that can withstand shocks from health emergencies.

Sierra Leone has some of the worst maternal and child health indicators in the world.[114] The Foreign Commonwealth and Development Office (FCDO) is investing £170 million to help improve the quality, availability, and accessibility of Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services to save lives, increase human capital and ultimately reducing poverty in the country.

Sierra Leone has become a focal country for the UK's manifesto commitment on 'Ending the Preventable Deaths' of mothers, children, and new-borns. The programme directly contributes to this goal and has worked to adapt quickly, through repurposing programme funds to support the Government of Sierra Leone's (GoSL) COVID-19 response and to maintain essential health services that reduce the impact of the pandemic on vulnerable women and children.

Phase 2 of the programme has been extended until October 2023 (with Montrose MELR involvement to end June 2023). This will ensure no break in service delivery while successor programmes are designed and procured as this process has been delayed due to COVID-19.

Purpose of the Endline Review

The overall purpose of the review is to develop a credible and comprehensive report on the SLiSL phase two programme, in order to directly inform future interventions in the health system. The review will:

- assess the progress made by all components of the SLiSL programme in fulfilling its agreed objectives through the planned activities;
- assess the efficiency and effectiveness with which resources have been used to generate results;

[114] The pregnancy-related mortality ratio (PRMR) is 796 deaths per 100,000 births (2019). The neonatal and under-five child mortality rates are 31 and 122 deaths per 1,000 live births, respectively (2019).

- include an assessment of the contributions made by the Technical Assistants provided through the SLiSL programmes and how these could be improved and made more efficient;
- include reference to how the SLiSL phase two programme has built on or coordinated with previous FCDO investments (including SLiSL phase 1) and non FCDO funded health system investments.
- identify persistent barriers to improving the health sector make practical recommendations on how future interventions should respond to these barriers.
- capture gaps and opportunities and identify lessons learned, for more robust and effective interventions in the health sector in the future.

The current project ends in October 2023, and so it is critical that lessons emanating from this programme are captured and shared with key stakeholders including the government, other donor agencies, implementing organisations amongst others, to inform subsequent programmes and interventions. The learnings documented from the project will be shared on the SLiSL website, with implementing consortium agencies, key stakeholders both state and non-state actors and donor agencies. The hope is that the operationalisation of the recommendations from the review report will lead to more efficient and effective future programming.

Methodology of the Endline Review

This review will focus on phase 2, considering that there are a detailed end of phase 1 completion report, and a March 2018 detailed break review that also captures all key phase 1 aspects. Phase 1 ended September 2018, and Oct-Dec 2018 was transition quarter from phase 1 to phase 2. The review will include references to key aspects and lessons learnt from phase 1.

This ToR aligns to the FCDO review policy and strategy (FCDO, June 2022)[115] and the DAC review criteria.[116]

The FCDO Evaluation Strategy and Policy June 2022 aims to reduce poverty by generating evidence and knowledge that informs effective decision making through four strategic outcomes:

> *Outcome 1: Strategic review evidence is produced and used in strategy, policy, and programming: Relevant, timely, high-quality review evidence is produced and used in areas of strategic importance for FCDO, HM Government (HMG) and international partners.*
> *Outcome 2: Review evidence is systematic and objective: Users have confidence in the findings generated from review of FCDO interventions, policies, and strategies.*
> *Outcome 3: Learning from review s is shared and used in decision-making: Review findings are accessible and actively communicated in a timely and useful way to inform future strategy, programme, and policy design.*
> *Outcome 4: FCDO has an evaluative culture, the right review expertise and capability*

The DAC evaluation criteria include relevance, effectiveness, efficiency, impact, sustainability, and coherence.

The proposed detailed objectives for the review are:

[115] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107762/FCDO-Review - Policy.pdf and
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107763/FCDO-Review - Strategy.pdf
[116] https://doi.org/10.1787/543e84ed-en

1. To independently verify SLiSL record of achievement as reported through its annual reviews and quarterly and annual reports and defined in the SLiSL Phase 2 and its extensions logical frameworks. A mix of qualitative and quantitative data will be used to verify SLiSL record of achievement including for example beneficiary interviews to supplement SLiSL's record of achievement.

2. To assess the extent to which the SLiSL phase 2 program performed well and was good value for money, using the OECD/DAC criteria[117] which include:
    - **Relevance:** Is the intervention doing the right things? For example, the *extent to which the aid activity is suited to the priorities and policies of the target group, recipient, and donor.*
        - To what extent are the objectives of the programme still valid?
        - Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives?
        - Are the activities and outputs of the programme consistent with the intended impacts and effects?
    - **Effectiveness**: *A measure of the extent to which an aid activity attains its objectives.*
        - To what extent were the objectives achieved / are likely to be achieved?
        - What were the major factors influencing the achievement or non-achievement of the objectives?
    - **Efficiency:** *How well are resources being used. Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted.*
        - Were activities cost-efficient?
        - Were objectives achieved on time?
        - Was the programme or project implemented in the most efficient way compared to alternatives?
    - **Impact:** *The positive and negative changes produced by a development intervention, directly or indirectly, intended, or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental, and other development indicators. The examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors, such as changes in terms of trade and financial conditions.*
        - What has happened as a result of the programme or project?
        - What real difference has the activity made to the beneficiaries?
        - How many people have been affected?
    - **Sustainability:** *Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.*
        - To what extent did the benefits of a programme or project continue after donor funding ceased?
        - What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?
    - **Coherence:** *Coherence is concerned with the extent to which other interventions (particularly policies) support or undermine the intervention, and vice versa. Includes internal coherence and external coherence: Internal coherence addresses the synergies and interlinkages between the intervention and other interventions carried out by the same institution/government, as well as the consistency of the intervention with the*

[117] https://www.oecd.org/dac/review /daccriteriaforevaluatingdevelopmentassistance.htm

relevant international norms and standards to which that institution/government adheres. External coherence considers the consistency of the intervention with other actors' interventions in the same context. This includes complementarity, harmonisation and co-ordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort.

- To what extent did interventions fit with other interventions in the country, health sector, and related institutions?

3. To inform the future health programming through:
    - Collating lessons learnt from the implementation Phase 2 and its extensions
    - Provision of recommendations on:
        - Data capture on PWD and other socially disadvantaged groups
        - Complementing / reinforcing other related UK Aid programming in Sierra Leone – both centrally funded and bilateral - including WISH, Global Funds, etc, especially on girls' education, adolescent girls' empowerment, and the demographic dividend?
        - Feasibility of cross-sectoral approach – bridging health and education
        - Need to focus (e.g., on specific health facilities, districts, or population groups) in the light of GESI/ equity considerations
        - Governance model for the next phase of programming
        - Sustainable future model for financing drug procurement/distribution incorporating other donors

The review team will answer the following questions on the report:

- What important lessons are there to learn from the SLiSL project implemented by the consortia?
- What do the lessons mean for future programme design, implementation, monitoring, and review ?
- How relevant was the SLiSL project to the needs and the institutional (MoHS, NMSA, National Emergency Medical Service [NEMS]) context? Was donor support consistent with national need/priorities?
- What has been the intermediate outcome of the SLiSL project in terms of changes in the quality-of-care systems in Sierra Leone?
- To what extent have the outcomes generated been relevant to improvements in the quality of health service delivery, particularly for vulnerable groups?
- What types of complementary actions have target institutions taken to support the SLiSL project and what has been their significance (influence)?
- To what extent do the gains identified at the intermediate outcome levels appear sustainable?
- To what extent did the project contribute to health system strengthening in Sierra Leone?
- To what extent was the project able to adapt/ flex to changing context and needs?

Main methods used during the review will be desk review, data analysis, key informant interviews, focus group discussions and field visits.

The review will be documented in a review report and a summary evidence brief which will be disseminated to relevant stakeholders. Key stakeholders include the MoHS, implementers of phase 2 (including extensions), other health sector implementers and development partners.

Specific Roles and Responsibilities of the Review Team

The FCDO SL office will be the owner of the review s, while Montrose – currently working as SLiSL MELR provider – will support FCDO with the review using both regular MELR team members (including VfM, technical lead, learning lead, medical devices, and research consultants) and external independent evaluator(s). The external evaluator(s) will lead the review and will be responsible for deliverables specified below. The existing MELR team will assist among others with provision of relevant data and documents (see Annex 1), and introductions to key informants.

The external evaluator(s) / MELR team should have experience in conducting review of FCDO funded projects including an understanding of FCDO approaches to VfM (4 E's) and should have knowledge of the project area.

Quality control will be provided by Montrose and FDCO SL. Montrose will work with an external consultant, while FCDO SL will engage with EQuALS (Evaluation, Quality Assurance and Learning Service - an external service which provides independent support for reviews) to do a light touch review of the ToRs and products of the review/reviews.

External Consultant(s)' Relationship with the MELR Montrose Team

- The Consultant will liaise with MELR technical lead Heidi Jalloh-Vos on any technical issues.
- The Consultant will liaise with Montrose programme manager, Vivian Nambozo, on any contractual issues.
- Outputs will be approved by the Montrose programmes director, Charlotte Kamugisha.

Deliverables of the External consultant(s)'

Deliverables to Montrose and FCDO
1. Inception report including a data collection plan and review tool
2. Presentation to FCDO
3. Draft report with key findings and recommendations
4. Final report in FCDO agreed format with key findings and recommendations

The final report should have maximum 25 pages without annexes, organized as follows:

- Executive summary (2 pages)
- An overview of project design (1-2 pages)
- Methodology for assessment used; research design, tools used, and data gathered and tabulated. (3-4 pages)
- Key findings (14 – 17 pages)
- Conclusion and recommendations (2-3 pages)

FCDO will provide any FCDO specific reporting template required for the endline review at the start of the endline review .

Timelines

Activity	Dates
Desk / literature review	1-12 May and ongoing
Meeting with FCDO to finalise ToR and have FCDO steer on the endline review before finalising the draft inception report	Between 3rd – 5th May
Submission of draft inception report to FCDO	8 May
FCDO comments on inception report	10 May
Interviews with key stakeholders, online	8 – 16 May
Final inception report	12 May
In-country interviews and meetings – Sierra Leone • Partners meeting – 17 May • Joint field visit – 18-19 May • Steering committee meeting – 24 May • Debrief meeting FCDO 23 May	17 - 24 May
Data analysis and report writing	25 May – 16 June
Presentation to FCDO – online	12 June
Submission of draft report to FCDO for one round of consolidated comments	19 June
FCDO comments to review team	23 June
Submission final report	30 June

Appendix 3: Review Matrix

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	**Secondary Data Tools**	**Secondary Data Source**
1.	**Relevance** – *the extent to which the programme is suited to the priorities and policies of the target beneficiaries, national and local partners, and donors.* 1.1 To what extent did the programme design align with the reproductive, maternal, newborn and child health priorities and policies of national and local government? 1.2 To what extent does the project design and implementation respond to beneficiaries' reproductive, maternal, newborn and child health needs (equity considerations for SLISL included place of residence (rural vs urban), gender and age group of beneficiaries (adolescent). For example, how far did the targeted intervention locations help in serving target populations? 1.3 To what extent does the programme design and implementation respond to the needs of frontline staff and managers responsible for service delivery. 1.4. Are the objectives of the programme still valid?	Briefing meetings with FCDO, partner presentations at partners and steering committee meetings KIIs – senior stakeholders Focus groups - beneficiaries	Document review	Log frame Background documents; core project documents: Break review and programme response to break review (e.g., budget decisions, changes in programme delivery), annual FCDO programme reviews, SLiSL case studies and national and district strategies and policies and DHIS data UNITE VfM Reports; MELR SLiSL VfM assessments.
2.	**Effectiveness** – *the extent to which the objectives have been achieved and the anticipated results have been realized.* 2.1 Were the project objectives/outcomes achieved/ likely to be achieved? 2.2 What were/ are the major factors influencing this?	Briefing meetings with FCDO, partner presentations at partners and steering committee meetings	Document review	Background documents; core project documents (SLiSL), Annual reports, Break review, Case study reports, M&E

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	2.3 To what extent have the accepted break review recommendations been actioned or fulfilled and helped achieve project objectives? 2.4 How far has the project been able to incorporate responsive approaches in terms of reach and service uptake for target populations in Sierra Leone? Are there any specific examples of initiatives that have worked and can inform targeting of reproductive, maternal, newborn and child health more widely in FCDOs' health programmes? For example, for rural or urban areas; for adolescents?	KIIs – senior stakeholders and programme implementation staff		data, achievements against logframe UNITE VfM Reports; MELR SLiSL VfM assessments.
3.	**Efficiency** – *the extent to which results were delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.* 3.1 Were the output-level targets achieved on time and on budget? If not, understand reasons why. For example, were there any timeline or resource allocation related challenges that needed significant alteration? 3.2 Is there evidence that outputs were cost-efficient? 3.3 Was the programme or project implemented in the most efficient way compared to alternatives?	Briefing meetings with FCDO, partner presentations at partners and steering committee meetings KIIs – senior stakeholders and implementing partners	Document review and triangulation	Background documents; partner M&E documentation, Project-level amalgamated documentation; core project documents (SLiSL); Break review; Annual reports**,** and most recent quarterly reports (March 2023); SLiSL annual VfM assessments; UNITE annual VfM reports; Updated VfM indicators (e.g., see

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
				UNITE report and data requests to UN).
4.	**Impact** – *the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the programme, directly or indirectly, intended, or unintended* 4.1 What has been the impact on the service delivery capacity of government and other partner capacities as a result of the SLiSL programme? For example, the utilisation of the infrastructure upgrading, availability of commodities, training, and the extent to which these have contributed to better reproductive, maternal, newborn, adolescent, and child health services? 4.2 How far have the various trainings provided to the project staff and to different stakeholders been useful in terms of knowledge gained or systems strengthening more broadly) – for example, systems such as referral, treatment are improved in the programme and longer-term? 4.3 Is there any evidence of changes in community awareness and demand for quality reproductive, maternal, newborn and child health services in programme districts? 4.4 Are there any aspects of the programme that were embedded in partner practice? For example, improved data management or other information systems. How have these influenced engagement with communities to sustain demand for quality reproductive, maternal, newborn and child health services?	Briefing presentation KIIs –project partners, frontline health workers FGDs - beneficiaries		Background documents; core project documents (SLiSL); Donor reports, SLiSL case studies, annual reports, and most recent quarterly reports (March 2023) MELR SLiSL Economic Review Report 2020; DHIS2 data

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	4.5 Cost-effectiveness: What is the intervention's ultimate impact on improving health outcomes, relative to the money and other resources invested in the programme intervention?			
5.	**Sustainability** – *whether benefits of the project or programme are likely to continue after donor funding has ceased* 5.1 Does SLiSL have a sustainability plan in place, and if so, to what extent has this been operationalised? 5.2 What are the prospects for the benefits of the programme continuing after donor funding has ceased? For example, is there any evidence of policy changes that have been stimulated by the programme? 5.3 What are the prospects for financial sustainability of the activities established under the project after donor funding has ceased? 5.4 What were/ are the major factors influencing achievement or non-achievement of sustainability of the programme?	Briefing presentation KIIs – senior stakeholders and project staff	Document review	Background documents; core project documents (SLiSL); key learning reports, annual reports such as MELR SLiSL VfM assessments, project planning and strategy documents.
6.	**Coherence/coordination** – *Includes internal and external coherence. The extent to which other interventions (particularly policies) support or undermine the intervention, and vice versa. The extent to which the programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.*	Briefing presentation KIIs – project partners	Document review	Background documents; core project documents (SLiSL); Break review; donor reports e.g., FCDO annual reviews,

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	6.1 To what extent did the planned design of interventions fit with other interventions in the country, health sector, and related institutions, if there was any variance, how did this affect programme implementation? 6.2 Were any new factors identified later in the course of Phase 2 implementation that were more relevant to the programme aim? If yes, how did the programme respond to these? 6.3 Given that this was a multi-partner programme with complex inter agency dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall? 6.4 What was the contribution made by technical assistance provided through the SLiSL programmes and how could this be improved and made more efficient? 6.5 How well has SLiSL been coordinated with any other partners' initiatives and programmes at local and national levels?	Focus Group Discussions – beneficiaries		SLiSL case studies and other key learning documents. For example, evidence of SLiSL coordination in the VfM assessments under Sustainability and Efficiency
7.	**Replicability/ scalability** - *the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.* 7.1 What aspects of this programme might be valuable and feasible to replicate in other FCDO or for partner programmes?	Briefing presentation KIIs Focus Group Discussions - beneficiaries	Document review	Background documents; core project documents (SLiSL); Break review; donor reports; FCDO and partners' strategic plans, case studies, internal and external

	Key Review question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	7.2 To what extent has the programme provided a model for RMNCAH service delivery, in the context of a health systems approach in Sierra Leone? 7.3 How well has learning about successes, challenges, gaps, and opportunities been captured and documented, in order to allow for learning to translate to more robust and effective health sector interventions in the future in Sierra Leone or to other RMNCAH programmes more widely ?			publications (e.g., newsletters, website) VfM assessments in effectiveness and programme management sections for information about learning and dissemination

Appendix 4: VfM principles and analysis across the review

Consideration of VfM principles within the review

A Value for Money (VfM) approach has been part of the programme since the beginning of Phase 2, after the development of a programme wide VfM Strategy and Framework by MELR[118]. Annual VfM assessments have used the VfM framework to provide evidence for VfM each year. This endline review is using the OECD/DAC Review criteria of Relevance, Effectiveness, Efficiency, Impact, Sustainability and Coherence which aligns to a large extent to the VfM framework criteria of Economy, Efficiency, Effectiveness, Cost-effectiveness, and Equity.

Therefore, VfM will be considered throughout each stage of this review including the design, data collection, analysis, and findings. The core questions from SLiSL's VfM Strategy and Framework will be reviewed, particularly during the development of the data collection tools, to ensure that the review areas include these VfM principles:

1. Is the SLISL programme buying inputs of the appropriate quality and the right price? (Economy)
2. How well is the SLISL programme converting inputs into outputs? (Efficiency)
3. How well did SLiSL integrate equity considerations in their intervention design? (Equity)
4. How is SLISL set up to ensure the programme adapts to changes in context, new evidence, and learnings to improve programme implementation? (Effectiveness)
5. How is SLISL setup to ensure intervention programme cost-effectiveness and sustainability? (Sustainability)

There will not be a standalone VfM assessment as this would duplicate the work conducted for each OECD/DAC Review criteria, but where there is not a direct match between the OECD/DAC criteria and FCDO's 5Es, we will ensure that the E is considered within the appropriate OECD/DAC Review area. Specifically, Equity considerations are relevant across all areas of the review and particularly within Relevance. Economy will be considered within the Efficiency section. Cost-effectiveness will be considered within the Impact section and the proposed approach is described within this appendix.

Efficiency Section

3.1 Were the output-level targets achieved on time and on budget? *If not, understand reasons why. For example, were there any timeline or resource allocation related challenges that needed significant alteration?*

The logframe outputs will be reviewed by exception, noting outputs that were not achieved on time or within budget (depending on availability of information within quarterly reports). Where targets were not achieved, contributing factors will be identified. Key informant interviews will be used to understand further any significant challenges.

Given the agreements in place with consortium partners on sharing financial data, we will use the financial data reported in quarterly reports to assess whether outputs were within budget.

Data source: Logframe; quarterly reports; key informant interviews

3.2 Is there evidence outputs were cost-efficient?

[118] MELR SLiSL Phase 2 Value for Money Strategy and Framework, updated 5 July 2021

The VfM indicators will be reviewed from the VfM framework, and these will provide some evidence for outputs 1, 2 and 4.

Output	VfM dimension	Indicator type	Measurement type	Indicators	Data source
Cross-cutting	Economy (Operational VfM)	Monetary	Benchmark	Administration and management cost as a proportion of total programme expenditure	Quarterly reports from beginning Phase 2 to latest report
1	Economy	Monetary	Benchmark	Unit cost of commodities procured FHCI tracer drugs: - Amoxicillin - ORS - Zinc - Oxytocin - Magnesium sulphate FP commodities: Injectable Depo-povera, Levonorgestrel implant	UNICEF and UNFPA.
4	Efficiency	Quantitative	Benchmark	Unit cost per UNITE clinical mentee	UNITE IRC VfM reports
2	Cost-efficiency	Quantitative	Benchmark	Cost per CYP; Injectable Depo-provera and Levonorgestrel implant	UNFPA
2	Cost-Effectiveness	Quantitative	Benchmark	Cost per CYP • CYP (PSS) • CYP (Outreach)	UNITE IRC VfM reports

Where there is limited data as there are no VfM indicators for some outputs, the logframe output indicator performance will be reviewed for evidence of efficiency. This will build on findings from 3.1 – where there may be examples of under or over performance this can be detailed further in this section.

Similarly, given the agreements in place with consortium partners on sharing financial data, we cannot request the financial data to analyse changes in the cost of inputs, so instead we will also request data/ analysis / evidence to demonstrate any examples of changes in cost drivers reported in the key informant interviews.

3.3 Was the programme or project implemented in the most efficient way compared to alternatives?

This question will first examine whether the programme was run efficiently using examples from the desk review and key informant interviews with the two consortia. Secondly, the review will investigate if there are suitable alternatives for comparison. It can often be hard to find a suitable alternative and so the evaluators will also ask if the IPs considered and adapted to alternative models of delivery during implementation. Previous VfM assessments and the key informant interviews will inform this section.

Cost-effectiveness approach

The purpose of this section is to propose a pragmatic approach to assess the SLiSL programme's cost effectiveness to judge whether the programme continues to represent good value for money. Ideally, this should be done by modelling the impact of the project using the LiST model of the SPECTRUM tool,

as done for the mid-term economic assessment[119], but data constraints are a limiting factor. Specifically, there is no new DHS survey data available which is the primary data input of the LiST modelling.

The mid-term assessment of the programme's cost-effectiveness, carried out using the SPECTRUM tool, revealed that £86,222,734 was disbursed between 2016 and 2019, potentially saving or averting 30,261 deaths. The SLiSL programme contributed to 32,038 lives saved or deaths averted, translating to approximately 1,634,354 life years saved. The cost per DALY averted by the SLiSL programme ranges between £81 to £417, depending on the attribution factor used. The upper bound of this cost per DALY estimate is lower than the estimated business case threshold of £577.

Since the mid-term impact modelling, the programme implementation has continued, within the context of COVID-19 pandemic and budget cuts, and the programme will end by October 2023. As mentioned, a new CEA would ideally measure the cost-effectiveness of the programme by modelling the impact of the project between 2020 till end of programme implementation using the SPECTRUM tool as was done for the 2016-2019 programme implementation years. However, there are constraints in terms of data availability, for example there has not been a DHS survey since 2019, data that is the primary data input of the LiST modelling.

It is noted that last year, for the SLiSL MELR VfM Assessment July 2021 – June 2022, it was not possible to update the model similarly due to the lack of DHS data. Instead, to assess the impact of the reduced budget on the programme implementation and the potential impact on the LiST model results, the SLiSL interventions and activities were reviewed to highlight the changes between the previous implementation period and the period under review last year. The review found that in the short-term it was expected that the findings of the previous LiST modelling would hold.

Objectives:

- Determine whether the SLiSL programme continues to represent good value for money by testing the validity of assumptions in the previous LiST modelling to determine the extent to which the findings still hold.

Data Requirement:
The data set required for this analysis include the demographic data for intervention areas, United Nations mortality estimates, service utilization data for selected RMNACH services and the programme cost data.

Data Analysis:
The timeframe for the analysis will be from programme inception to December 2022. A trend analysis of the service utilisation data for key maternal and perinatal indicators will be carried out. The mortality trend for the maternal and perinatal mortality will also be analysed. The trend analysis is expected to show whether there is an increase or decrease in service utilisation pattern and correlate with the mortality estimate. All these are expected to also correlate with the estimate of Lives saved.

For this analysis, the programme timeline will be divided into 2 periods, demarcated by the availability of survey data. Period 1 will be from 2016-2019 (where the survey data was available and Spectrum tool used for modelling) and period 2 will be between 2020 to the end of programme. For period 1, the number of Lives Saved estimated using the SPECTRUM tool will be correlated to the UN mortality estimate and the service utilizations statistics. For period 2, the estimate of lives saved will not be available, however, based on the observation from period 1 and the availability of UN mortality estimate

[119] Monitoring, Evidence, Learning and Review of FCDO Saving Lives in Sierra Leone (SLiSL). Economic Review (Cost-Effectiveness Analysis) of the SLiSL Programme for 2020 Annual Review. Submitted: 14 September 2020. Revision: 12 November 2020. Montrose MELR.

and service utilization trend for period 2, we will be able to make a judgement on the direction of the number of lives saved.

Parameter (Trend)	Phase 1 (2016-2019)[120]	Phase 2 (2020-2022)	Comment
Mortality estimate	Available from the UN Mortality estimate	Available from the UN Mortality estimate	
Service utilization	Available from the DHIS	Available from the DHIS	This will be interpreted along with the population data. To understand whether the change in utilization is driven mainly by the population changes or by other factors
Number of Lives saved/DALY averted	Available from Mid-term assessment (Impact modelling using LiST)	Not Available.	We will rely on the trend in 1&2 to determine the direction of this parameter. Whether the parameter will tend towards the base, lower or upper limit of the estimates obtained during the midterm modelling.
Programme Implementation cost	Available on DevTracker	Available on DevTracker (TBC)	

Additional information on the programme implementation assumptions, intervention quality and effectiveness will be obtained from the qualitative data gathered from the end of programme assessment and other previous assessment that has been carried out (review programme reports). These information will also provide more context behind the observed service utilization and mortality trends observed. Trend analysis of the cost data will also be carried out to understand how the programme implementation cost has changed across the two phases and see the correlation between the result and the cost.

Result and Discussion:
We will represent findings of the 2016-2019 modelling together with an update on the assumptions used. We will draw findings from the qualitative review of changes in programme design (reference the previous work); and a review of trends in quantitative indicators tracked by the programme and other sources such as service utilisation data.
This analysis will not produce an updated cost per DALY estimate, rather it seeks to rediscuss the findings from the 2016-2019 model in the context of health indicators 2020.

Limitations:
The main limitation to this assessment is non availability of survey data and the need to use the DHIS data and rely on the United Nations mortality estimates as these data sets are quite different from what was used for modelling in 2020. Hence, we cannot use the same methodology that was used for the previous CEA.

[120] The division of the programme into phase 1 and 2 is mainly for the purpose of this analysis and is driven by the period where there is availability of survey data for impact modelling (phase 1) versus when the data is not available (Phase 2)

Appendix 5: KII and FGD Interview Guides

Appendix 5 contains two interview guides for: i) Key informant interviews; ii) Focus group discussions with beneficiaries and each are address in turn. The questions listed are designed to be used as a **guide** for each interview and focus group.

Interview Guide for Key Informant Interviews

Interview outline (time allowed: up to 1 hour)

1. Introductions according to local protocol (up to 5 mins)
2. Very brief recap on purpose of interview, scope of questions and how responses will be used. Invite clarification questions. (5 mins)
3. Main discussion (up to 45 mins)
4. Closing formalities (up to 5 mins)

Interview schedule

Select questions from the main interview guide to shape interviews with key informants according to the following colour coding:

- National level implementing partners, government representatives and donor representatives.
- District-level implementing partners, government representatives (e.g., DHMT)
- Frontline health workers in primary health care and community level staff (note these informants will mostly be involved in FGDs, covered in a separate topic guide. Where individual KIIs are used, this guide will apply)

Review Questions	Sub Questions and Probes	Interviewees
1. Relevance – *the extent to which the programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors.*		
1.1 To what extent did the project design align with the reproductive, maternal, newborn, child, and adolescent health (RMNCAH) priorities and policies of national and local government?	1.1.1 What priority is given to RMNCAH health by national and local government relative to other areas of health? 1.1.2 How *(if at all)* has SLiSL influenced thinking and programming in SL? 1.1.3 What policies and other contextual factors *(if any)* have affected planning decisions? 1.1.4 Please provide specific examples of relevance. 1.1.5 Please provide specific examples of where priorities have changed. For example, in repose to budget adjustments?	**Questions 1.1.1 to 1.1.5** MoHS representatives National implementing partners. Donors e.g., FCDO District-level implementing partners, government representatives. Frontline health workers
1.2 To what extent does the programme design and implementation respond to beneficiaries' reproductive, maternal, newborn and child health needs (equity considerations for SLiSL included place of	1.2.1 What needs assessment processes are used? 1.2.2 How *(if at all)* are beneficiaries involved in planning and review at any level? (**Prompt:** needs assessments or research? Please provide examples where this has happened.) 1.2.3 How was this information used in project management?	**Questions: 1.2.1 to 1.2.3** MoHS representative District-level implementing partners, government representatives. Frontline health workers.

Review Questions	Sub Questions and Probes	Interviewees
residence (rural vs urban), gender and age group of beneficiaries (women, adolescents, and children). For example, how far did the targeted intervention locations, training and technical assistance for ministry and frontline health workers help in serving target populations, in terms of supporting equitable accessibility to quality health services?		
1.3 To what extent does the programme design and implementation respond to the needs of frontline staff and managers responsible for service delivery.	1.1.3. In what ways has it impacted ways of working? (**Prompt:** planned and unintended ways)	MoHS representative District-level implementing partners, government representatives. Frontline health workers.
1.4. Are the objectives of the programme still valid?	1.4.1. Can you tell me a little bit more about this?	MoHS representative National Programme Staff Donor: FCDO District-level implementing partners, government representatives. Frontline health workers.
2. Effectiveness – the extent to which the objectives were achieved, and the anticipated results have been realized.		
2.1 Were programme objectives/ outcomes achieved or not, and what were the major factors influencing this?	2.1.1 What was the overall achievement against logframe targets? (**Probe:** RMNCAH targets and financial targets) 2.1.2 What are the principal reasons for variation across the project sites (**Probe:** financial targets) 2.1.3 Did anything make it easy to achieve the targets? Difficult? [**Prompt:** MELR evidence and learning, programme coordination or outreach and support through other related programmes – e.g. "champions" of the programme in related areas/ projects? Are the right people (organisations) involved and fully	**Questions 2.1.1 to 2.1.5** MoHS representative National Programme Staff Donor: FCDO District-level implementing partners, government representatives. **Questions 2.1.3 to 2.1.5 more specifically for** Frontline health workers

Review Questions	Sub Questions and Probes	Interviewees
	engaged? Is the current partner set sufficient?] 2.1.4 What impact *(if any)* have these had on service delivery? On treatment? [**Probe:** any evidence of decisions or changes?) Can you give examples? 2.1.5 Can you think of anything which would have made achieving objectives and outcomes easier?	
2.2 To what extent has progress been made against break review recommendations and most recent annual review recommendations been actioned or fulfilled and helped achieve programme objectives?	2.3.1 What progress has been made against the recommendations of last year's FCDO annual review? Against the break review? 2.3.2 What are the reasons for any recommendations that have not been actioned?	**Questions 2.3.1 to 2.3.2** National level implementing partners. District level implementing partners. Donor: FCDO
2.3 How far has the project been able to incorporate responsive approaches in terms of reach and service uptake for target populations in Sierra Leone? Are there any specific examples of initiatives that have worked and can inform targeting of reproductive, maternal, newborn and child health more widely in FCDOs' health programmes? For example, for rural or urban areas; for adolescents; for strengthening DHMTs?	2.4.1 How has the project incorporated responsive approaches into programming of target groups? 2.4.2 What *(if anything)* has worked particularly well? 2.4.3 How applicable are these approaches to targeting more widely in FCDO' RMNCAH health projects?	**Questions 2.4.1 to 2.4.3** National level implementing partners. **Questions 2.4.1 to 2.4.2** District level implementing partners
3. Efficiency – the extent to which results were delivered with the least costly resources possible, and the way resources have been efficiently managed and governed to produce results.		
3.1 Were the output-level targets achieved on time and on budget? If not, understand reasons why.	3.1.1 What made it easy to deliver the programme efficiently? What made it difficult? [**Probe:** For example, were there any timeline or resource allocation related challenges that needed	**Question 3.1.1** National level implementing partners. District level implementing partners.

Review Questions	Sub Questions and Probes	Interviewees
	significant alteration? For example, how flexible and responsive was the programme to change?]	
3.2 What is the evidence that outputs were cost-efficient?	3.2.1 In what way *(if at all)* has routine and enhanced monitoring in relation to the programme supported this evidence?	**Question 3.2.1** National level implementing partners. District level implementing partners. Frontline health workers
3.3 Was the programme or project implemented in the most efficient way compared to alternatives?	3.3.1 For example, within the programme are their examples of where the programme changed direction and decided to things in a different way (**Probe:** based on learning, results)	**Question 3.1.1** National level implementing partners. District level implementing partners.
4. Impact – the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the programme, directly or indirectly, intended, or unintended		
4.1 What is the impact on the service delivery capacity of government and other capacities as a result of SLiSL? For example, the utilisation of the infrastructure upgrading, availability of commodities, technical assistance, and the extent to which these have contributed to better RMNCAH services for patients at district and community levels?	4.1.1 What *(if anything)* has been the impact on service delivery capacity for government and other partner staff as a result of the programme? For staff trained or supported through ongoing technical assistance: What *(if anything)* has changed since being part of the programme? For You? Your team? Your clients? *Can you say more about this?* ○ How has participation in the programme affected you? ○ *What difference has it made to your work (if any)?* ○ *What difference has it made to your clients (if any)? (**Probe**: TA support and the impact for RMNCAH services.)* *4.1.2 Are there any downsides to being involved in the programme?* (**Probe:** any change including: other work neglected, problems with clients served? Relations with other colleagues who have not been trained?)	**Questions 4.1.1 to 4.1.2** National level implementing partners. District level implementing partners. Frontline health workers
4.2 How far have the various trainings provided to different stakeholders been useful in terms of knowledge gained and	4.2.1 What has been the impact of training on knowledge? For staff trained: What impact has this training had for You? Your team? Your clients? *What has*	**Question 4.2.1 to 4.2.2** District level implementing partners. Frontline health workers

Review Questions	Sub Questions and Probes	Interviewees
strengthening service delivery (e.g., planning, quality of services delivered, referral system) in the programme and longer-term?	changed because of training? *Can you say more about this?* ○ How has training affected you? [**Probe:** knowledge] ○ *What difference has it made to your work (if any)?* ○ *What difference has it made to your clients (if any)? (**Probe**: referral systems.)* 4.2.2. Has anything unexpected emerged as a result of training? (**Probe:** Are there any signs of staff transferring skills to and from SLiSL? Has attention to this programme meant other issues are neglected?	
4.3 What was the impact on community awareness and demand for quality RMNACH services in programme districts? For example, from the results of ongoing monitoring or other information sources	4.3.1 What has been the impact on community awareness and demand for RMNCAH services? Can you provide specific examples of this?	**Question 4.3.1** District level implementing partners Frontline health workers
4.4 Are there any aspects of the programme that were embedded in practice, and how has this influenced engagement with communities to sustain RMNACH service demand?	4.4.1. What evidence is there of aspects of the programme (in part or in full) being embedded in practice? (**Probe:** management-based decision-making, annual work planning) 4.4.2 How *(if at all)* has this influenced engagement with communities to sustain demand for RMNCAH services? Can you say more about this? Are there any specific examples?	**Question 4.4.1 to 4.4.2** National level implementing partners. District level implementing partners. Frontline health workers
4.5 Cost-effectiveness: What is the intervention's ultimate impact on improving health outcomes, relative to the money and other resources invested in the programme intervention?		**Question 4.5** National level implementing partners. District level implementing partners

Review Questions	Sub Questions and Probes	Interviewees
5. Sustainability – whether benefits of the programme are likely to continue after donor funding has ceased.		
5.1 Does the project have a sustainability plan in place, and if so, to what extent has this been operationalised?	5.1.1 What will happen to the work undertaken in this programme when the programme has closed? **Probe:** Is there a sustainability plan? Is this being operationalised? 5.3.2 What systems and structures needed to be established to ensure sustainability of service delivery? Are these in place? 5.3.3 If the whole programme will not continue, is there anything that will/ could continue? Can you say more about this? 5.3.4 What would you consider to be the most critical change required in helping partners to establish and maintain quality RMNCAH services?	**Questions 5.1.1 to 5.3.4** National level implementing partners. District level implementing partners.
5.2 What are the prospects for the benefits of the programme continuing after donor funding has ceased? For example, is there any evidence of policy changes that have been stimulated by the programme?	5.2.1 What are the prospects for the benefits of the programme continuing after donor funding has ceased? **Probe:** can you say more about this? 5.2.2 What *(if any)* policy changes have been stimulated by SLiSL? Can you say a bit more about this? 5.2.3 What is the reach of these policy changes – local facility, district, national?	**Questions 5.2.1 to 5.3.3** National level implementing partners. District level implementing partners. Frontline health workers
5.3 What are the prospects for financial sustainability of quality RMNCAH services established under the SLiSL programme?	5.3.1 What is the likelihood that management, coordination, and service delivery will be financially sustainable? Can you say more about this? 5.3.2 If interventions are not financially sustainable, what (if anything) could be done at this stage to enhance the prospects of financial sustainability?	**Questions 5.3.1 to 5.3.2** National level implementing partners. District level implementing partners
5.4 What were/ are the major factors influencing achievement or non-achievement of		**Questions 5.4.** National level implementing partners. District level implementing partners.

Review Questions	Sub Questions and Probes	Interviewees
sustainability of the programme?		
6. Coherence/ coordination – Includes internal and external coherence. The extent to which other interventions (particularly policies) support or undermine the intervention, and vice versa. The extent to which the programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.		
6.1 To what extent were the assumptions[121] on which the various programme components built, valid, and if there was any variance, how did this affect implementation?	6.1.1 Considering the assumptions around which project components were built, how valid were these assumptions? [**Probe:** assumptions such as prevalence data, government health infrastructure and HR] 6.1.2. How *(if at all)* did any variance from these original assumptions affect programme implementation?	**Question 6.1.1 to 6.1.2** National level implementing partners. District level implementing partners.
6.2 Were any new factors identified later during implementation that were more relevant to the programme aim? If yes, how did the programme respond to these?	6.2.1 Did any new factors emerge during implementation that were more relevant to the original problem statement? Can you tell us more about these? 6.2.2 How (*if at all)* did the project respond to these? i) What *(if any)* changes were made? ii) What were the reasons for no changes being made?	**Questions 6.2.1 to 6.2.2** National level implementing partners. District level implementing partners.
6.3 Given that this was a multi-partner project with complex inter agency dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall?	6.3.1 How many programme partners were you working with for this RMNCAH project? 6.3.2. Can you describe what it's like havening this number of partners? 6.3.3 How have partner relations functioned? (**Probe**: how has coordinated been achieved?) What made this easy? What made it difficult? 6.3.4 What are the current gaps in partner relations? What are the prospects of filling them?	**Questions 6.3.1 to 6.3.4** National level implementing partners. District level implementing partners. Frontline health workers

[121] These may include population statistics (e.g., maternal deaths), government health infrastructure and HR, etc.

Review Questions	Sub Questions and Probes	Interviewees
6.4 What was the contribution made by technical assistance provided through the SLiSL programmes and how could this be improved and made more efficient?	6.4.1 Focusing on technical assistance how did this impact the programme (**Probe:** positively and negatively in intended and unintended ways) 6.4.2 How could this be improved and made more efficient?	**Questions 6.4.1 to 6.4.2** National level implementing partners. District level implementing partners.
6.5 How well has the project been coordinated with any other partners' initiatives and programmes at local and national levels?	6.4.1 Focusing more broadly, how *(if at all)* has the programme been coordinated with other partner initiatives and programmes either locally or nationally? (**Probe:** What links exist to other major programmes that could be mutually reinforcing?) 6.4.2 How *(if at all)* did coordination ensure the active participation and easy flow of information between all stakeholders? Can you provide examples? 6.4.3 What made wider partner coordination easy? What made it difficult?	**Questions 6.4.1 to 6.4.3** National level implementing partners. District level implementing partners. Frontline health workers

7. Replicability/ scalability – the scope and potential for the programme, or elements of the programme, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.		
7.1 What aspects of the programme might be valuable and feasible to replicate in other FCDO RMNCAH programmes or for other partner programmes?	7.1.1 Would you recommend the approach used in this programme to others? Who? **Or** What is it that makes you say you would not recommend it? (**Probe:** in which context might this not be the best approach?) 7.1.2 Which components of the programme are suitable for replication? **Probe:** Can you give an example of this? 7.1.3 What would you say to others who were thinking of implementing the approaches you have used?	**Questions 7.1.1 to 7.1.3** National level implementing partners. District level implementing partners.
7.2 To what extent has the programme provided a model for RMNCAH health service delivery, in the context of a health systems approach in Sierra Leone?	7.2.1 Considering the approaches used (national, district and community) in what way *(if at all)* have these provided a model for RMNCAH delivery in Sierra Leone? Can you say a bit more about that? 7.2.2 What *(if anything)* would you change about the model? Can you say a more about that? 7.2.3 Would you recommend this model to others? 7.2.4 What would you say to others who were thinking about implementing this model? 7.2.5. If you had to think of three top recommendations/ tips in relation to getting others involved in the programmes like SLiSL, what would they be?	**Questions 7.2.1 to 7.2.5** National level implementing partners. District level implementing partners.
7.3 How well has learning about successes, challenges and gaps been captured and documented, in order to allow for learning to translate to this and other programmes?	7.3.1 What have been the top three learnings from the programme? (**Probe:** successes and challenges) 7.3.2 How are learnings captured and documented? 7.3.3 What evidence is there that learning has been translated to this and other projects?	**Questions 7.3.1 to 7.3.3** National level implementing partners. District level implementing partners. Frontline health workers

Interview Guide for Focus Group Discussions with Beneficiaries

Discussion outline (time allowed: up to 60mins)

1. Introductions: (up to 10 mins): participants' roles and longevity in the project
2. Very brief recap on purpose of discussion, scope of questions and how the response will be used. Invite clarification questions. (5 mins)
3. Main discussion using selected prompts from discussion schedule(up to 45 mins)
4. Closing formalities (up to 5 mins)

It is essential that a brief is given before interviews begin that beneficiaries are not being asked to share personal details of their treatment but for their broad views about the RMNCAH services**.** Their participation in this interview is entirely voluntary and they can withdraw at any time. Interviewees may also refuse to answer any questions they do not want to answer. There is no penalty for withdrawing from the interview.

Discussion schedule

Select from a sub-set of questions from the main interview guide to shape discussions in line with the composition of each group. Put questions to the group in the form of simplified discussion prompts shown in Column 2. The overarching questions (e.g., 1.1.; 2.1) are a guide and link for the interviewer the overall review framework.

Review Questions	FGD discussion prompt
1. Relevance – *the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.*	
1.1 To what extent did the project design align with the RMNCAH health priorities and policies of national and local government?	1.1.1 Tell me a little about the services you know are available in this facility/ or to this community? **Without mentioning any personal details.** Thinking about RMNCAH services, how well have the services in this facility supported you and/ or your family? **Probe:** How services do that? (e.g., fully addressed your concerns; dealt with you in a timely manner) 1.1.2 How (*if at all)* was feedback gathered from you as you used the service? (**Probe**: for example, where you asked by nurse if you had any questions of feedback? Invited to complete a written feedback form?)
2. Effectiveness – the extent to which the objectives have been achieved and the anticipated results have been realized.	
2.1 Were the project objectives/ outcomes achieved or not, and what were the major factors influencing this?	2.1.1 Thinking about the services you received (without mentioning any personal details). What made your visit to the service easy? **Prompt:** seen by the right staff, medicines available] What made it difficult? [**Prompt:** service too far away, not seen by the right staff, medicines unavailable] 2.1.2 Can you think of anything that would have improved your experience of this service?
4. Impact – the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme	

Review Questions	FGD discussion prompt
	4.1.1 What *(if anything)* has been the impact of having this service for you and your family? 4.1.2 Are there any downsides to using the service? 4.1.3 Have you used these types of services before? If yes: How do your recent experiences differ from previous experiences? Can you tell me more about that? 4.1.4 Thinking more widely about the community served by this facility - What has been the impact of this service on community awareness and demand for RMNCAH services? Can you tell me more about that?
5. Sustainability – whether benefits of the project are likely to continue after donor funding has ceased.	
	5.3.1 What would you consider to be the most critical change *(if any)* required in helping service users like you have access to routine, quality RMNCAH services?
7. Replicability/ scalability – the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.	
7.1 What aspects of this project might be valuable and feasible to replicate in other RMNCAH programmes?	7.1.1 What would you say to others who were thinking of using these services? 7.1.2 What *(if anything)* would you change about the service? Can you say a more about that? 7.1.3 Would you recommend the service to others? Who? Why do you say this? 7.1.4. If you had to think of three top tips in relation to encouraging others to use in the service, what would they be?

Appendix 6: Tool for summarising review team member notes

This tool is designed to be completed by review team members when summarising the results of:
i) interviews and FGDs and ii) document review

Review Team Member:_____

Date: _____

Interviewees: _____

	Key Review question to be addressed	**Data Collection Technique**	
		Primary Data Source KII or FGD (Mark as appropriate)	Secondary Data Source Document review (Mark X)
1.	**Relevance** – *the extent to which the programme is suited to the priorities and policies of the target beneficiaries, national and local partners, and donors.*		
2.	**Effectiveness** – *the extent to which the objectives have been achieved and the anticipated results have been realized.*		
3.	**Efficiency** – *the extent to which results were delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.*		

	Key Review question to be addressed	Data Collection Technique	
		Primary Data Source KII or FGD (Mark as appropriate)	Secondary Data Source Document review (Mark X)
4.	**Impact** – *the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the programme, directly or indirectly, intended, or unintended*		
5.	**Sustainability** – *whether benefits of the project or programme are likely to continue after donor funding has ceased*		
6.	**Coherence/coordination** – *Includes internal and external coherence. The extent to which other interventions (particularly policies) support or undermine the intervention, and vice versa. The extent to which the programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.*		
7.	**Replicability/ scalability** - *the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.*		

Appendix 7: Team roles and responsibilities

Position	Role
Core Review Team	
1 Team Lead (External Consultant)	• Attend and lead the team in the initial briefing with FCDO • Coordinate team members' inputs with the MELR team, attend and support internal review planning meetings and provide first level quality assurance of team members' deliverables • Provide regular progress update to MELR technical lead, FCDO and Montrose as required • Lead the development and finalisation of the inception report, including data collection tools • Coordinate data collection plans with MELR team • Lead overall data gathering • Prepare and present preliminary findings at debriefing session in-country at the end of the field visit if required and before the draft report is submitted to FCDO • Coordinate data analysis • Lead review report writing and finalising the review report
3 MELR Team Members (LAMP) - Value for Money	• Provide support to the team lead in review implementation around VfM and programme effectiveness, scheduling online partner interviews and supporting the development of data collection tools • Contribute to data collection in online interviews and in particular, lead VfM aspects of data collection. During review interviews focus in particular on effectiveness, efficiency, sustainability and assessing the applicability of recommendations within the SL context. • Contribute to data analysis, leading on aspects of efficiency and VfM. • Contribute to the review report writing, as agreed with the Team Leader. This may include developing short impact/ VfM snapshots.
1 MELR team member – Technical Lead	• First point of contact between SLiSL, Montrose and FCDO for planning and coordinating review • Lead documentation gathering for document review • Lead/coordinate quantitative data extraction for VfM data analysis. • Lead/coordinate any other quantitative data analysis • Day-to-day oversight and support to review team to plan and deliver quality work on time • Coordinate and support quality assurance of the design, implementation, analysis, and report writing for the review
Remaining MELR Sierra Leone team/ Kampala Montrose Team support	
1 MELR team member - Data analyst	• Data extraction and analysis support, with focus on DHIS2
Admin, finance, and logistics support. (Montrose Kampala Team)	• Support to all aspects of the review including travel to Sierra Leone and in-country • Preparing and overseeing the relevant consultant contracts
QA support (Montrose Kampala Team)	• Technically quality assure the inception and review reports

Appendix 8: Summary list of key documents for review

- SLiSL business case
- 2018 Phase 1 Break review report (part 1 and 2)
- Phase 2 SLiSL overarching Logframe / ToC including Phase 2 logframe/ToC development notes
- 2020 Desk Based Review report
- SLiSL Annual review reports for phase 2 period
- Phase 2 consolidated quarterly reports (and UN / UNITE quarterly reports) including annexes (includes risk registers)
- Phase 2 joint visit reports
- Phase 2 deep dive minutes / reports
- Phase 2 partner and steering committee minutes and presentations
- Phase 2 learning event reports
- VfM reports
- PEA reports
- Phase 1 / 2 SLiSL Data analysis reports
- SLiSL Research reports
- SLiSL STTA reports including medical devices consultant reports
- Technical assistance ToRs and reports (to be obtained from UN, UNITE, FCDO and Montrose)
- Relevant MoHS strategies/policies and frameworks
- UNITE learning event products
- DHIS2 and relevant national surveys
- UNITE phase 2 baseline report/data

Appendix 9: List of Key Informant Interviewees

Stakeholder	Organisation	Name	No. KIs
GoSL	MoHS	Directorate of Policy Planning and Information (DPPI)	1
		Acting Coordinator, Infection Prevention and Control Programme	1
		Director, Human Resources for the Health Directorate	1
		Director National Medical Supplies Agency (NMSA)	1
Funder	FCDO	Human Development Team Leader Senior Programme Manager & SLiSL SRO (Senior Responsible Owner) Health Advisor	3
	Global Fund	Fund Portfolio Manager, Sierra Leone	1
INGO	Population Services International (PSI): the Presidents' Malaria Initiative (PMI).	Country Representative Programme Staff Malaria Lead Programme Staff PMI	3
	Helen Keller International	Country Director	1
UN consortium	UNICEF	Health Specialist (CHSS) Health Specialist (MNCH/ HIV) Health Specialist (MNH) Health Specialist, Supply chain System Strengthening	4
	UNFPA	Programme Coordinator Maternal Health Technical Specialist Finance Analyst	3
	WHO	Program Management Officer Medical Officer for Child health Technical Officer (SRH) Nutrition Lead Epidemiologist	5
UNITE consortium	CCU	Senior Team Leader MEL Co-ordinator	2
	Concern Worldwide	National Health Coordinator	1
	Crown Agents	Previous and current programme staff	2
	Doctors with Africa (CUAMM)	Country Programme Manager M&E Lead	2
	GOAL	Programme Coordinator Programme Manager	2
	IRC	Programme Coordinator	1
	Kings Global Health Partnerships Sierra Leone	Partnership Lead, Sierra Leone Director Kings College Partnerships	2
	Marie Stopes Sierra Leone	Deputy Director Programme Operations RM&E manager	2
	Restless Development	Head of Programmes Programme Officer	2
MELR	Montrose	Technical lead Medical devices and infrastructure	2
Total			**42**

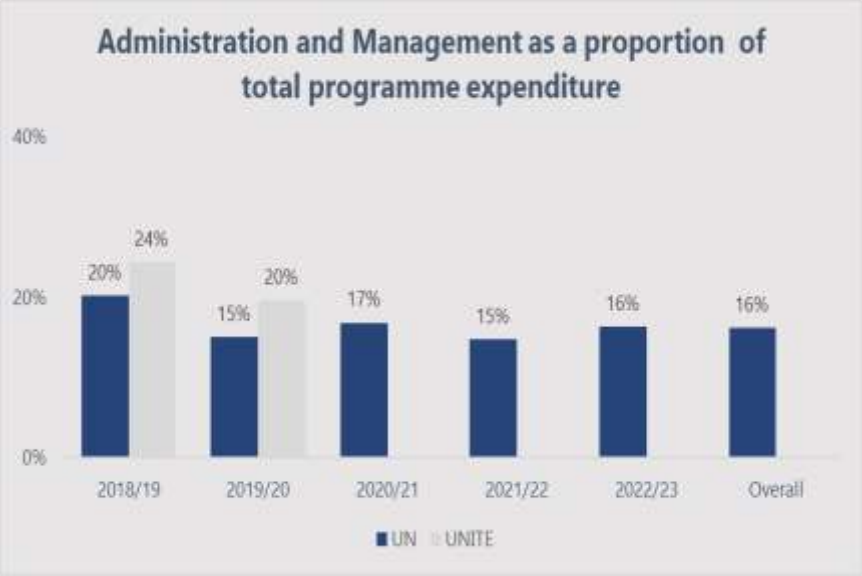
Appendix 10: Participants List: Joint Field Visit Participants

No	Name	Designation	Organization
1	Mohamed Lonko Koroma	Accountant	MoHS DHMT-Bombali
2	Jean Mwandira	PCS	UNFPA
3	Haja Kadiatu Jalloh	SCHO	MoHS DHMT-Bombali
4	Mohamed Bundu	Data Officer	MoHS DHMT-Bombali
5	Aiah M. Biankee	SPH/Supt	MoHS DHMT-Bombali
6	Mohamed Rashid Kargbo	Malaria	MoHS DHMT-Bombali
7	Tamba Daniel Moiwa	DIO	MoHS DHMT-Bombali
8	Ibrahim J. Kanu	DOO 2	MoHS DHMT-Bombali
9	Idrissa Tarawalie	WASH Officer	MoHS DHMT-Bombali
10	Sahr A. Pessima	Deputy Director - Programme Operations	Marie Stopes Sierra Leone
11	Sahr M. Kamara	Area Coordinator	GOAL - SL
12	Roseline Ansumana	Health Programme Manager	GOAL - SL
13	Simpson Bakarr Yajoh	Programme Manager	FCDO - SL
14	Zynab Rodney-Sandy	Programme Manager	FCDO - SL
15	Flaviour Nhawu	UNITE Consortium Coordinating Unit (CCU)	UNITE/IRC
16	Lahai Ansu	DISM	DHMT - MoHS Bombali
17	Mariatu S. Bangura	DCM	GOAL SL
18	Denis L. Janneh	DCM	GOAL SL
19	Ahmed Conteh	Area Coordinator	GOAL SL
20	Mohamed Eisa	Health Coordinator	GOAL - SL
21	Lutomia Mauaala	Health Specialist	UNICEF
22	Dr Mohamed I. Bangura	Regional Pharmacist	MoHS - DHMT Bombali
23	Kamanda T. Kamara	Human Resource Assistant	MoHS - DHMT Bombali
24	Amanda Parry	Programme Manager	FCDO - SL
25	James Bunn	Health Advisor	FCDO - SL
26	Beatrice Jalloh	DHS II	MoHS - DHMT Bombali
27	Mohamed Conteh	Risk Com. Lead	MoHS - DHMT Bombali
28	Hawa Kallon	DHSI	MoHS - DHMT Bombali
29	Sulaiman D. Kamara	Dist. M&E	MoHS - DHMT Bombali
30	Arelujaguru T. Sesay	DHRO	MoHS - DHMT Bombali
31	Frida Kuda Tegule	Programme Coordinator	MELR Montrose
32	Lynne Elliott	External Consultant	MELR Montrose
33	Dinsie Williams	Medical Devices Expert	MELR Montrose
34	**Andrew Dauda**	**Researcher**	**IfD / supporting MELR Montrose**
35	Muallem Kamara	Researcher	IfD / supporting MELR Montrose
36	Regina Bash-Taqi	Learning and Evaluation Lead	MELR Montrose
37	Dr Joseph K. Sesay	Medical Superintendent	MoHS - DHMT Bombali
38	Alexander M. Karim	Blood Bank Head	MoHS - DHMT Bombali
39	Adama Kalokon	Midwife	MoHS - DHMT Bombali
40	Nenneh Jalloh	Midwife	MoHS - DHMT Bombali
41	James Pessima	RCH - Coordinator	MoHS -RCH Directorate

No	Name	Designation	Organization
42	Sewa Marrah	DVOR	MoHS - DHMT Koinadugu
43	Foday Samura	DSO	MoHS - DHMT Koinadugu
44	Sheriff Bassie Kargbo	M&E Officer	MoHS - DHMT Koinadugu
45	Amadu Mannah	DSO	MoHS - DHMT Koinadugu
46	Mohamed A.B. Fofanah	M&E Officer	MoHS - DHMT Koinadugu
47	Amadu Koroma	Data Clerk	MoHS - DHMT Koinadugu
48	Finah Koroma	DSO	MoHS - DHMT Koinadugu
49	Yandi Fofanah	Nutrition Unit	MoHS - DHMT Koinadugu
50	Samuel K. Conteh	Data Clerk	MoHS - DHMT Koinadugu
51	Abdulai C. Shaw	M&E Officer	MoHS - DHMT Koinadugu
52	Simon K. Kamara	Office Assistant	MoHS - DHMT Koinadugu
53	Ibrahim F. Koroma	District Pharmacist	MoHS - DHMT Koinadugu
54	Mathew K. Gibateh	DSO II	MoHS - DHMT Koinadugu
55	Kadiatu Lahai Mansaray	DISM	Marie Stopes Sierra Leone
56	Francis P. Kanneh	DSMC	MoHS - DHMT Koinadugu
57	Zainab Juldeh Bah	MDSR Coordinator	MoHS - RCH Directorate
58	Ishmael Turay	M&E Officer	MoHS - DHMT Koinadugu
59	Dr Tom Sesay	Director	MoHS - RCH Directorate
60	Dr Steven Fornie	District Medical Officer (DMO)	MoHS Koinadugu
61	Idriss Bangura	DSO	MoHS - DHMT Koinadugu
62	Ibrahim B. Kamara	NTD Focal Act.	MoHS - DHMT Koinadugu
63	Mohamed K.D. Koroma	M&E Unit	MoHS - DHMT Koinadugu
64	Dominic S. Mansaray	Data Officer	MoHS - DHMT Koinadugu
65	Alhaji M.A. Turay	SOC-MONS	MoHS - DHMT Koinadugu
66	Isatu Jalloh	Midwife	Kabala Govt Hospital - Koinadugu
67	Rosaline Thoronka	Midwife	Kabala Govt Hospital - Koinadugu

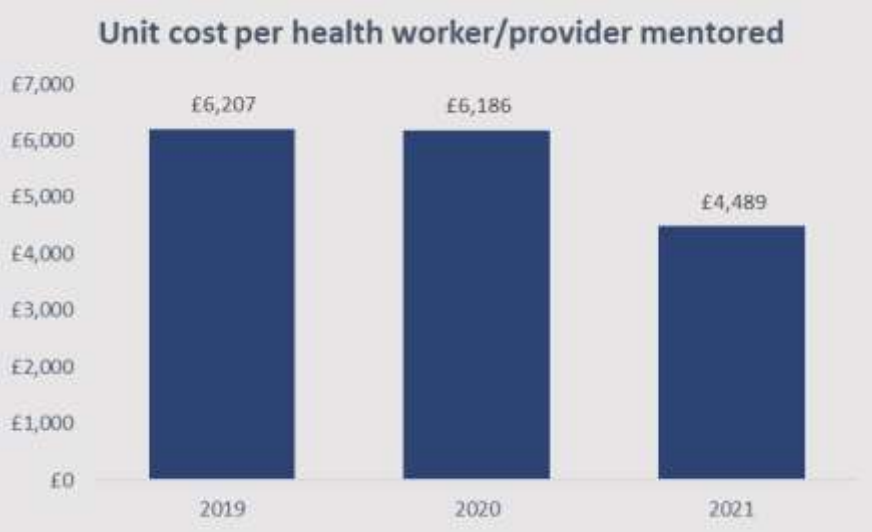
Appendix 11: Efficiency appendix: analysis and examples

Table A: SLiSL VfM indictors analysis

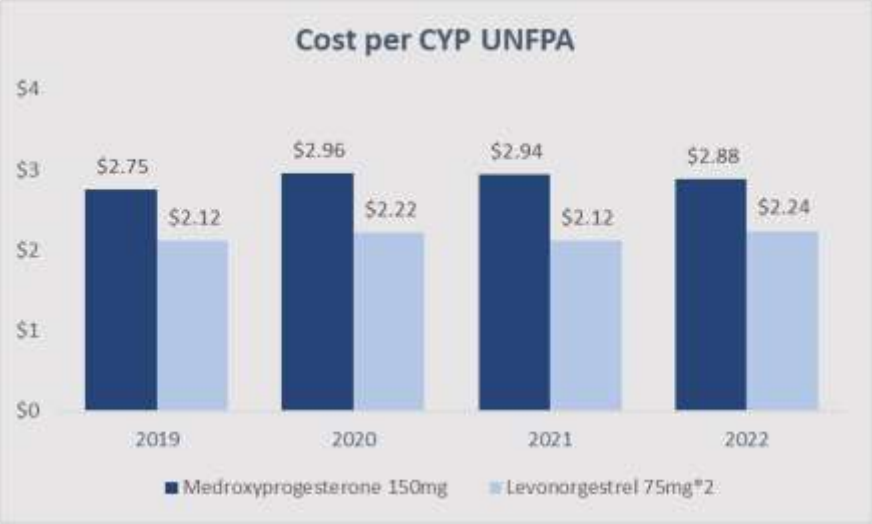
VfM indicators	VfM narrative
Economy	
	UN Consortium Administration and management costs as a proportion of total programme expenditure decreased over time. For UNITE, the administration and management indicator reduced from 24% in 2018/2019 to 20% in 2019/2020. During this period, the staff cost included in the financial report was only for those staff involved in programme coordination while cost of salaries for other programme staff was part of the programme activities. However, from 2020/2021 upwards, the total staff cost was reclassified to include the cost of programme staff directly involved in implementation as well as the staff involved in programme coordination which significantly increased the A&M cost as a proportion of total programme cost. As a result, the figures from 2020/2021 till date could not be presented as part of this report.
Unit cost of Commodities / **Jan-Jun 2020** / **Jul 2020 – Jun 2021** / **Jul 2021 – Jun 2022** / **Jul 2022 – May 2023** **Dispersible Amoxicillin** 2.29 2.43 2.37 1.58 **Oxytocin (10 ampoules)** 2.13 1.92 2.11 2.14 **Magnesium Sulphate Injection (10 ampoules)** 6.31 4.98 4.88 4.94 **Oral Rehydration Solution (ORS, 100 sachets)** 6.06 6.23 4.5 5.43 **Zinc Sulphate (100 tablets)** 1.37 1.23 1.19 1.2 **Levonorgestrel Implants (per set)** 8.067 7.94 7.78 8.502	The unit cost of commodities for dispersible amoxicillin, Magnesium Sulphate, ORS, Zinc Sulphate, reduced between January 2020 and May 2023. However, the unit cost for oxytocin and injectable contraceptive fluctuated during the periods under review while there was a reduction in unit cost between Jul 2021-Jan 2022.

Injectable contraceptive (Vial)	0.687	0.74	0.735	0.721	

Efficiency

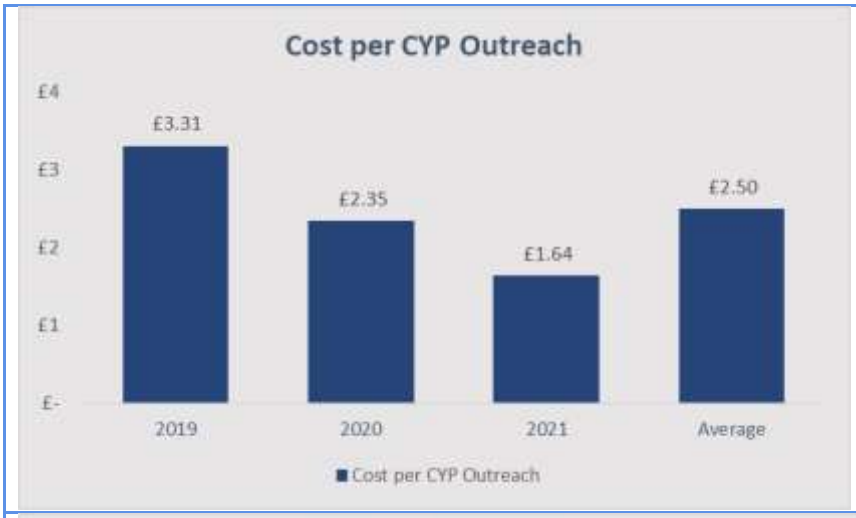


The unit **cost per health worker/provider mentored** reduced year on year between 2019 and 2021 for the UNITE clinical mentorship programme.



The **cost per CYP for Medroxyprogesterone** increased between 2019 and 2021 (£2.75 to £2.94) but reduced to £2.88 in 2022 while the **cost per CYP for levonorgestrel** fluctuated with slight increase from 2019 and 2022 (£2.12 to £2.24).
The cost per CYP is within a benchmark range (see table D in this appendix).

Cost-Effectiveness



The cost per CYP for family planning outreaches decreased over time between 2019 and 2021 from £3.31 to £1.64. However, cost per CYP for family planning PSS increased from £3.34 in 2019 to £4.74 in 2021. This was driven by CYP numbers which decreased during COVID-19. Overall, average cost per CYP (£2.50 for outreach and £4.39 for PSS) within a benchmark range (see table D in this appendix).

Table B: Efficiency examples by output that demonstrate the approaches used by SLiSL implementers

Output 1 - Improved efficiency of procurement and supply of FHC drugs and FP commodities and support for nutrition commodities
NMSA developed a pilot supported by Crown Agents for a low-cost efficient model for last-mile distribution using in-house vehicles, with similar condition of commodities and delivery coverage at 25% of the cost[122]. However, after significant increases of fuel prices in the country, third-party logistics distribution was better able to mitigate high prices as it is centrally organised.
The substitution of a type of amoxicillin requiring reconstitution[123], for the cheaper and more stable amoxicillin dispersible tablet, had significant implications regarding transport, storage, and distribution.
Challenge: SLiSL IPs identified the opportunity to increase efficiency by coordinating supply of commodities from other partners such as Global Fund, e.g., combining distribution of Global Fund commodities and FCDO commodities. This has not yet been possible due to the challenge with timings and the release of funds cycle within Global Fund.
Output 2 Increased demand for and availability of family planning services for adolescents and young people

[122] Value for Money/Cost Efficiency Report, Ex-post analysis using log frame results and actual expenditure in January 2019 to December 2022. Submitted April 2o22)
[123] Amoxicillin syrup in bottles with powder for reconstitution for children

MSSL and RD co-delivered interventions in an efficient and effective model. The availability of family planning services from MSSL during outreaches conducted by Restless Development led to increased attendance and participation of beneficiaries.
RD avoided the use of financial incentives during community outreaches and passing on information and knowledge. This was challenging, particularly after Ebola period when use of financial incentives and DSAs was widespread, and it reduced motivation of people to attend events. However, attendance steadily improved over time once people understood the rationale behind the sessions.
Output 3: Improved availability of functional hospitals to receive RMNCAH referrals according to standards
While MoHS was developing a plan focusing on child/maternal health guidance and training, UNICEF brought stakeholders together for discussions with Chief Medical Officer (CMO) to reduce duplication. Three trainings on child, maternal and safety measures were brought together into one compiled training package and one training plan with the Directorate of Nursing and Midwifery and Directorate of Reproductive and Child Health (DRCH). UNICEF involved JICA who wanted to do a similar programme with the Directorate of Nursing and Midwifery. Other examples of efficiency during training activities include training conducted in health facilities rather than centrally e.g., WHO training of HCWs on paediatric neonatal audit.
Output 4 Improved HRH capacity to conduct RMNCAH services
UNITE clinical mentorship did not use financial incentives or DSAs for the mentees. This affected motivation of mentees but ultimately ensured that the mentees were motivated by their own development and improvement of clinical skills, rather than unsustainable, financial incentives.
Challenge: Attrition of mentees has been an issue for the UNITE clinical mentorship programme. A drop-out analysis by UNITE found that 162 of 405 mentees dropped out before completion, largely (59%) due to mentees being transferred to a non-SLiSL facility[124]. IPs worked with DHMTs to find solutions to this problem, including developing non-financial incentives for the district clinical mentors (DCMs) and for mentees and better planning to ensure mentees are not transferred.
Higher costs do not mean less value for money: The cost per UNITE clinical mentee in rural areas compared to urban areas is slightly more. The cost per mentee increased on average £14 for every extra kilometre travelled by the mentor from the district centre to a health facility (CHC)[125] highlighting that reaching harder to reach groups, and considering equity, can cost more. UNITE also found that overall improvement in clinical skills took a longer time than expected due to the lower baseline clinical competency of mentees. UNITE described the importance of improving skills in this cadre because they are most likely to treat pregnant mothers at health facilities. Cost per CYP for family planning public sector strengthening sites mentored by MSSL is higher than for cost per CYP for family planning outreach services. This is because fewer CYPs are generated in the PSS sites due to less skilled health worked. However, PSS sites are considered a success story, showcasing UNITE's strategy to ensure ownership and leadership from the government, and providing a sustainable model for GoSL in community health centres[126].
Output 5 Quality of care framework for RMNCAH services implemented and monitored
The UN consortium reported how the long term, multi-year programme, has enabled them to bring in funds from other shorter-term donors to maximise results. UNITE consortium has examples demonstrating this, such as the request from Wellbodi Partnership to help the organisation coordinate their activity improving measurement of blood pressure in mothers. Wellbodi had a small budget for the project but leveraged on SLiSL's spread across all districts to increase coverage of this intervention, important for maternal health.[127]
Output 6: Functional DHMTs with increased capacity for district level planning and service delivery for key areas of RMNCAH-supported by strengthened L/HMIS and coordination

[124] FCDO MELR SLiSL VfM Assessment July 2021 – June 2022.
[125] SLiSL UNITE Cost-Efficiency report Jan 2019-December 2022
[126] Value for Money/Cost Efficiency Report, Ex-post analysis using log frame results and actual expenditure in January 2019 to December 2022. Submitted April 2022. UNITE consortium.
[127] KII

UNITE benchmarked all DHMT and hospital generators and examined use of fuel for vehicles.[128]
Output 7: Functional emergencies/disease surveillance, preparedness, and response
Support to disease surveillance system, following initial investment to create the system is now being maintained at a low cost (e.g., £6000 per quarter).

Table C: Efficiency examples demonstrating how SLiSL implementers adapted to change and found alternative ways of working

Output 1 - Improved efficiency of procurement and supply of FHC drugs and FP commodities and support for nutrition commodities
After budget cuts in April 2021, Crown Agents developed a flexible and needs-based approach to the provision of their technical assistance. For example, after the handover of the allocation and quantification processes to NMSA, they then provided targeted support when needed for those processes.
UN consortium used a number of strategies to overcome supply chain challenges caused by COVID-19. Extreme global demand for IPC supplies, long lead times and price volatility were mitigated for example by relying on strong coordination with regular contact with UNICEF's Regional Office to advocate for support to Sierra Leone and coordinating logistics for chartered flights. For example, UNFPA and UNICEF leveraged on UN sister-organisations like WFP to airlift commodities.
Output 2 Increased demand for and availability of family planning services for adolescents and young people
Demand creation was reduced after the exit of Restless Development, and MSSL saw a drop in numbers of clients accessing services. MSSL developed a strategy, at low cost, to embed demand creation within their activities (using CHWs for 2 days, 1 day prior, and on the day). Demand creating activities are now conducted by CHWs on the day before and on the day of service provision activities (MSSL KI). This is a lower cost approach, and more sustainable than contracting a third-party organization. However, time is needed to see the impact of this change on results. Also, CHWs are not a dedicated resource for this activity, and they have competing priorities for their time.
COVID-19 brought the continuation of a shift from face-to-face to virtual for some activities e.g., online supportive supervision. Remote clinical audits using clinical audio-visual assessments (CAVA) kept costs low while maintaining clinical quality. Family planning outreached teams were able to use CAVA to receive regular feedback on clinical quality for clients and identify areas for improvement, without the costs of travel. CAVA was limited to outreaches only as the government did not allow audio-visual assessment in the health facilities sites for public sector strengthening (PSS).
Output 3: Improved availability of functional hospitals to receive RMNCAH referrals according to standards
With the exit of Restless Development, UNITE consortium worked with non-SLiSL partners such as Red Cross during blood bank drives to increase demand for blood donors.
Output 4 Improved HRH capacity to conduct RMNCAH services
UNITE clinical mentorship adapted to funding cuts while maintaining the number of mentees. The number of mentors was cut so the remaining mentors adapted by refocusing mentorship topics and redistributing their time across mentees more strategically and identifying mentees who needed greater support. This was enabled by strengthened data monitoring systems which helped plan the distribution of mentors' time across mentees effectively. Responsibility of technical support for mentors was redistributed to more programme staff such as District Delivery Managers and this did increase the scope of their work. Mentorship sessions were concentrated on the key Basic EmONC topics which was a better fit with the mentees' skill-level[129].
Challenge: UNITE was concerned the reduction in mentorship topics may be inefficient and end up costing more in long term if mentees are to reach a high-level of competency.

[128] FCDO MELR SLiSL Jan-June 2020 VfM Refresh Assessment submitted 14 September 2020
[129] IRC KII

Challenge: Multiple donors can make it difficult to report on activities accurately. UNFPA and WHO stated in the quarterly reports when an activity was partly funded by a different donor.
IPs leveraged resources from other donors and partners to cope with budget cuts. UNFPA identified support from other donors for its midwifery programme e.g., scholarships partly covered by Islamic Development Bank and partly by SLiSL. WHO used grants from Swedish International Development Cooperation Agency (SIDA) to support midwifery and another grant from a Large Anonymous Donor (LAD) that supported antenatal, post-abortion and other care elements in reproductive health.
Output 5 Quality of care framework for RMNCAH services implemented and monitored
The reduced budget, and increased costs (due to fuel increases and increased government DSAs) was mitigated by DHMTs by organising maternal death investigations with fewer individuals. The findings of the investigation were then investigated at the DHMT-level among the entire team. PHU in-charges meetings were also used as convenient, lower cost forum for discussing these cases.
Output 6: Functional DHMTs with increased capacity for district level planning and service delivery for key areas of RMNCAH-supported by strengthened L/HMIS and coordination
The improved capability of DHMTs reduced the impact of fuel increases on DHMT activities. Their strengthened capacity to manage their budgets, plan and prioritize their activities, and bring in other partners to provide resources needed meant that meetings could continue on a monthly basis. However, in some districts, meetings were reduced to bi-monthly meetings.
IRC reported that during this period, post budget-cuts, that some PHU in-charges meetings were held at the chiefdoms with 2 or 3 supervisors from the DHMT going to the chiefdoms, which reduced travel costs and allowed meetings to continue.
Output 7: Functional emergencies/disease surveillance, preparedness, and response
Production of alcohol-based rub reduced the costs and increased availability during COVID-19. The estimated cost of locally produced hand rub is between United States Dollar (USD) 2-3 per 500mls. This is compared to USD 10 for 350ml when buying from the local market. This production was stopped when the cost of raw materials became too high to be cost-efficient.
Technical assistance under the SLiSL programme was able to provide additional assistance relevant to support of COVID-19 response activities for no additional cost e.g., the biomedical engineer conducted assessment and planning for the oxygen supply in the country, assembly and installation of an oxygen plant using old oxygen plant components at the treatment centre at 34 Military Hospital. Technical assistance also included training of biomedical assistants and service users of oxygen concentrators and other medical equipment on preventive maintenance and repair.

Table D: Benchmarks for cost per CYP [130]

Name of Project	Total CYP	Total Cost	Cost per CYP	Remarks
IRMNH (UNFPA) ***Sierra Leone***	181,791	£235,763	£1.08 (2015)	The cost was captured as total expenditure on FP services
IRMNH (MSSI) ***Sierra Leone***	149,858	£384,538	£2.56 (2015)	MSSL included some indirect/support cost in their estimation.
Scaling Up Family Planning **I** ***Zambia***	272,897		£15	Logistics cost high because of sparse population density of Zambia
Scaling Up Family Planning II ***Zambia***			£11	

[130] IRMNH VfM Benchmarking report 2017

Name of Project	Total CYP	Total Cost	Cost per CYP	Remarks
Prevention of Maternal Death from Unwanted Pregnancy -PMDUP ***Multi-country Sub Sahara Africa***	987,238	NA	£5.70 for 2015 (£8.4 if public sector cost was included)	All programme costs were used and not just those relating directly to service delivery. Cost to public sector not included in the estimate (issue with attribution here).
Ghana Adolescent Reproductive Health Programme (GHARH)	1,663,453	£8,568,867	£5.15	Based on data reported in programme log frame.
Global programme to enhance Reproductive Health (RH) commodity security (UNFPA) ***Low- and Middle-Income Countries***	28.4	£50	£1.73 (2014)	Procurement & Distribution expense for the commodity (Direct cost).

Appendix 12: Detailed progress against logframe indicators over Phase 2 period

See the standalone Word document containing Appendix 12.

Appendix 13: Additional information on analysis conducted for review of impact modelling

Data collection:

The **data** used for the analysis included the demographic data for intervention areas, United Nations mortality estimates, service utilization data for selected RMNACH services and the programme cost data. The indicators considered for this assessment are categorized broadly into coverage, quality, equity, and mortality indicators. The timeframe for the analysis was from programme inception to December 2022.

Table 9: Conceptual framework for impact modelling review

Parameter (Trend)	Comment
Mortality estimate	Not comparable with the DHS data because of difference in methodology
Service utilization	Interpreted along with the population data to understand whether the change in utilization is driven mainly by the population changes or by other factors
Number of Lives saved/DALY averted	Relied on the trend in 1&2 to determine the direction of this parameter.
Programme Implementation cost	This cost is from the perspective of the funder, so it is not economic cost

Data Analysis:

A trend analysis of the service utilisation data and mortality estimates was carried out for period 1 (2016-2019) and period 2 (2020-2022).

Parameters	Findings
Mortality estimate	There was a reduction in trend for mortality estimates considered between 2016 and 2019. However, maternal mortality increased between 2019 and 2020 while infant mortality, Under 5 mortality, neonatal mortality, adolescent mortality, indicators reduced between 2019 and 2021. For period 2, data was not available (UN estimates) for maternal mortality ratio for 2021 and for all indicators for 2022.
Service utilization	There was a downward trend in the oral polio, pentavalent, pneumococcal and rota virus vaccine doses administered between 2016-2019 except for IPV and measles 2nd dose which showed a consistent increase during the period. However, this changed significantly with an upward trend for all vaccine types between 2020-2022. Like the vaccine doses, proportion of women attending antenatal 4th visit reduced between 2016 and 2019 but increased in 2020 and 2021 before a downward slope in 2022. Proportion of skilled and facility deliveries increased in between 2016 and 2019 but reduced significantly in 2020 before an increase in 2021 and remained the same in 2022. Proportion of children given vitamin A increased between 2016 and 2019 and 2020 to 2022. The proportion of diarrhoea cases treated with ORS and Zinc showed an upward trend between 2016-2019 before a reduction in 2020 and increased in 2021 while in 2022 reduced marginally. As per Quality of Care, the proportion of newborns breastfed is higher compared to acceptable threshold of 70%. According to DHIS data, immediate postpartum uterotonic was administered for PPH prevention in majority of deliveries and this compares favourably with acceptable threshold of 100%.

Equity	The equity indicator considered is the adolescent mortality rate. This indicator showed a downward trend in phase 1 of the programme
Programme implementation cost	The total programme expenditure increased from about £17m in 2017/2018 to £26m in 2019/2020 fiscal year. In period 2, total programme expenditure reduced significantly from about £28m in 2020/2021 fiscal year to about £10m in 2021/2022.
Number of lives saved/DALY averted	The investment in Sierra Leone health system have potentially saved the lives or averted death in about 40,261 (26,482 - 52,823) mothers, under five children and newborn (including stillbirths) while the SLISL programme contributed 32,038 (21,540 – 41,601) of the lives saved/deaths averted. In addition, between 2016 to 2019, the total number of Life-Years saved by the SLISL programme and other stakeholders in the health sector of Sierra Leone is 1,634,354 (1,099,752 – 2,125,301), while in terms of DALY averted, the SLISL programme contributed to about 1,025,216 (689,280 – 1,331,232) DALY averted. Most of the mortality estimates between 2020-2021 showed a decline which suggests that - lives saved/deaths averted will increase. Figures show the estimated intervention coverage increased in the second period of this analysis suggesting that number of lives saved/death averted may have increased and furthermore, quality of care indicators compare favourably with acceptable thresholds.

Discussion:

LiST Parameters	Effect on Lives Saved	Findings from analysis
Cause-Specific Mortality	Reduction in cause-specific mortality because of high intervention coverage and effectiveness results in an increase in number of lives saved	Cause-specific mortality estimates reduced in period 1 and continued to reduce for years data was available in period 2 and this would most likely result in an increase in the number of lives saved in the second period of the analysis.
Intervention Effectiveness	Increase in intervention effectiveness is expected to increase the number of lives saved.	The Quality of Care (QoC) indicators for which benchmark data was available were either at par or better than acceptable threshold and shows improved quality of care on the programme which would have increased the number of lives saved.
Intervention coverage levels	Higher coverage levels mean a larger portion of the population is receiving the intervention resulting in increase in number of lives saved	High coverage levels were observed for majority of coverage indicators in phase 2 period which means a larger portion of the population received these intervention which would likely result in

		increase in number of lives saved.
Population	Large populations generally have a higher number of deaths compared to lesser one so have the potential to have a high number of lives saved.	The population estimate available for the country increased year on year in both implementation phases and most likely would have had a higher number of deaths each year compared to countries with lesser population so there is a potential to have a high number of lives saved.

Conclusion:

In conclusion, there is a high likelihood that findings from the 2019 economic evaluation of the programme still hold but this can only be ascertained with a CEA for the period 2020-2022. Between 2016 – 2019, the country witnessed significant health system shocks including recovering from Ebola and the COVID-19 pandemic. Although there were significant resources available within the health system from the government and funding partners during this period, these shocks amongst other health system challenges, would have affected how efficiently the financial resources available were used. Since the impact evaluation (covering the time period 2016-2019), there has been improvement in the health system as it has moved beyond these shocks and efforts focused on improving the coverage, quality, and effectiveness of service delivery, as evidenced by the service delivery results provided by the programme during the impact modelling review. Even though funding from the SLiSL programme reduced significantly after the impact modelling time period, the continued impact of the SLiSL programme and that of other funding partners and government efforts, would have contributed to the improvement in the coverage and quality of health services provided. This is likely to have resulted in a higher number of lives saved. A future CEA would need to consider the appropriate level of attribution that reflects the SLiSL's contribution to the higher number of lives saved.

Appendix 14: Additional evidence of the importance of SLiSL to RMNCAH in Sierra Leone

Example 1: Free drug supply

Commodity supply to support free health care: a multi-pronged approach

SLiSL used a multi-pronged approach to improve commodity supply to support free health care; procuring free health care drugs and commodities, contraceptives, and nutrition supplies through the UN consortium and at the same time strengthening the national supply chain system and operating a system of co-financing of commodities with the GoSL.

To strengthen the supply chain system, SLiSL Crown Agents from the UNITE consortium worked with MoHS to develop and establish the National Medical Supplies Agency (NMSA). By July 2020, NMSA had taken over all activities from the Directorate of Drugs and Medical Supplies (DDMS) in the MoHS. Crown Agents embedded long-term and short-term technical assistance in NMSA, such as training in use of budget templates to prepare and guide FHCI / FP distributions and also working jointly with NMSA staff to develop an allocation tool. This support led to the handing over of key processes to NMSA such as quantification and allocation by 2021. When budgets reduced in 2021, Crown Agents ensured their technical assistance could be flexibly used, responding to requests from NMSA officials and providing technical assistance in areas that NMSA required continued support. Crown Agents worked to streamline the FHCI and Family Planning distribution including setting up a policy for four distributions each year, although in practice at times there were three distributions per year[131]. Additionally, SLiSL supported improved warehouse organisation and management and improved stock take procedures. NMSA improved stock accuracy levels from 1.2% in January 2020 to 61% in January 2021[132]. Crown Agents and UNITE identified that progress made at the national level revealed persistent problems at district level including issues with last mile distribution (from district level to health facilities) that required further support.

Co-financing of commodities was planned from the outset. For the procurement of commodities, from the beginning of the programme, SLiSL and FCDO advocated for the co-financing of commodities with GoSL. This emphasised government commitment and encouraged independence from donors and increased financial sustainability of the FHCI commodities. Original plans were for increased GoSL commitment to funding commodities each year during the SLiSL programme with 10% co-funding in 2019, 30% co-funding in 2020 and a commitment given in 2021 to provide 50% of the cost of FHCI commodities. This also included, for the first time, allocations and budget lines for nutrition commodities, blood supplies and distribution.

Although GoSL has allocated budget for the FHCI and FP commodities, the release of funds has not fully occurred, largely due to fiscal challenges. The COVID -19 epidemic exacerbated this problem which saw any (small) financial resources from GoSL, and staff, diverted to the COVID-19 vaccination campaign.

There are still insufficient FHCI and family planning commodities available in Sierra Leone and while FCDO is the only funder of FHCI commodities in the country, it is not enough. According to FCDO the expected cost for FHCI commodities in the country is between $22-24 million/ year, so at best only 25% of the required commodity costs are covered even with FCDO funding – as a result stockouts of commodities are commonplace. To maximise the amount of commodities available, the UN consortium has leveraged funds for reproductive health commodities from the UNFPA Global Program (UNFPA Supplies Partnership Program) and UNICEF supported MoHS to apply for the nutrition match-fund scheme at UNICEF, a sustainable financing option for procurement of RUTF (Ready to Use Therapeutic Food) for severe acute malnutrition.

In addition to procuring commodities, the UN consortium supplemented the work done by UNITE. For example, UNFPA supported the development of an integrated supply chain strategy, covering areas of governance, decision-making, distribution, warehousing, and logistics capacity. Overall, SLiSL took a harmonised approach while promoting the supply chain management reforms and in this way SLiSL strengthened systems beyond RMNCAH to support wider health systems in Sierra Leone.

[131] FCDO MELR SLiSL VFM Assessment July 2020-June 2021, Final report submitted 25 October 2021
[132] UNITE Lessons learned from Saving Lives in Sierra Leone programme, April 2022

Example 2: The Success of Community Outreach

Community outreach to support family planning and community blood donations.
Community demand creation activities for family planning and blood donation drives were conducted creating awareness and encouraging stakeholder participation to address social and cultural barriers through effective social behaviour change and communication strategies. Activities used different approaches including community outreach, door-to-door sensitization, and engaging community members to reach the most deprived, hard-to-reach communities and vulnerable populations from particularly hard-to-reach areas such as Thambaka chiefdom in Bombali district. When funding for community outreach was reprioritised (FY2022/23) Marie Stopes Sierra Leone were able to draw on other donor support for community outreach although SLiSL support was seen as a loss – with activities such as client exit surveys curtailed.

Community blood drives were successfully used to support blood donations in Sierra Leone. In the context of limited funding for blood supplies and support for blood donations SLiSL's decision to include support for blood supplies was considered significant in contributing to reductions maternal deaths. MDSR investigations point to common concerns around insufficient blood supplies linked to maternal deaths.

> "*…there is very little funding from government (last time I checked the entire program has USD 5,000 – 7,000 allocation from Government including from supplies) and funding going forward will help protect gains made. FCDO has provided massive support for the blood drives. While FCDO may not be able to support it in the way they have done that is a support FCDO should think critically about this support especially since a lot of MDSR investigations revealed that non-availability of safe blood is a big concern for, and in some cases cause of, maternal deaths.*" Senior INGO staff member

Given the limited support to safe blood supplies in Sierra Leone FCDO is likely to have made an important impact on reducing maternal deaths.

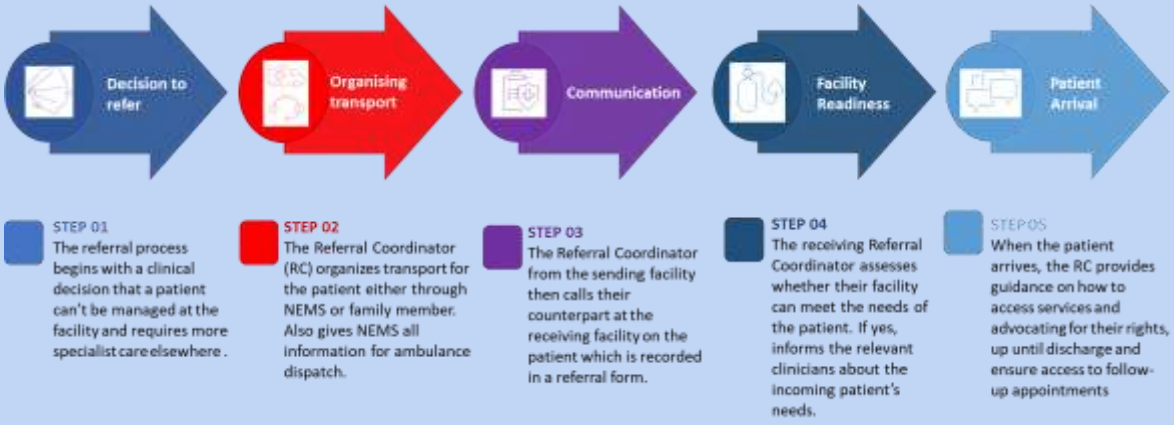
Example 3: Sierra Leone's referral system

The right care at the right time - building support for the national referral system in Sierra Leone under SLiSL[133]

With support from FCDO and others[134], the GoSL established (and continues) the country's first nationwide referral system in 2017 – the National Emergency Medical Services (NEMS). Between 2017 and 2021, King's Global Health Partnerships (KGHP) actively supported the development of the referral coordination element of the system, through hospital-based referral coordinators, enabling over 73,000 patients to access timely, appropriate, life-saving care. An assessment showed 14,266 referrals recorded nationwide between November 2017 to October 2018. The majority of referrals were for mothers (Maternity cases: 50.6%) and children under 5 (39.2%). Of all 14,266 referrals 93.8% survived and left hospital.

Saving Lives provided support to retain referral coordinators in all district and regional hospitals. Referral coordinators organise referrals from lower-level facilities to hospitals and ensure everything on the receiving side is ready for when the referral arrives. In 2021, as part of plans to sustain the service, the referral coordinators were integrated into NEMS and are now managed and funded by the GoSL. However, of the 56 referral coordinators, only 28 have been absorbed by the NEMS payroll, leaving a gap in staff numbers and there have been issues with funding salaries due to limited resources. There are reports that referral coordinators will be transferred from NEMS and placed under (district) hospitals. Although challenges remain, typically availability of ambulances, mechanical failures and fuel shortages, the referral process is established (see figure below). In addition, Saving Lives (through the UNITE Consortium) stepped in to provide some fuel for ambulance support (note, this was mainly fuel from flexible funds provided to DHMTs rather than directly to NEMS) to district and regional hospitals, as NEMS only covered certain types of referrals and did not cover inter-district referrals.

In the field, there was evidence of health facilities having the referral number posted prominently in their delivery rooms and accounts of local plans being made to transport expectant mothers with a community member who had access to transport.

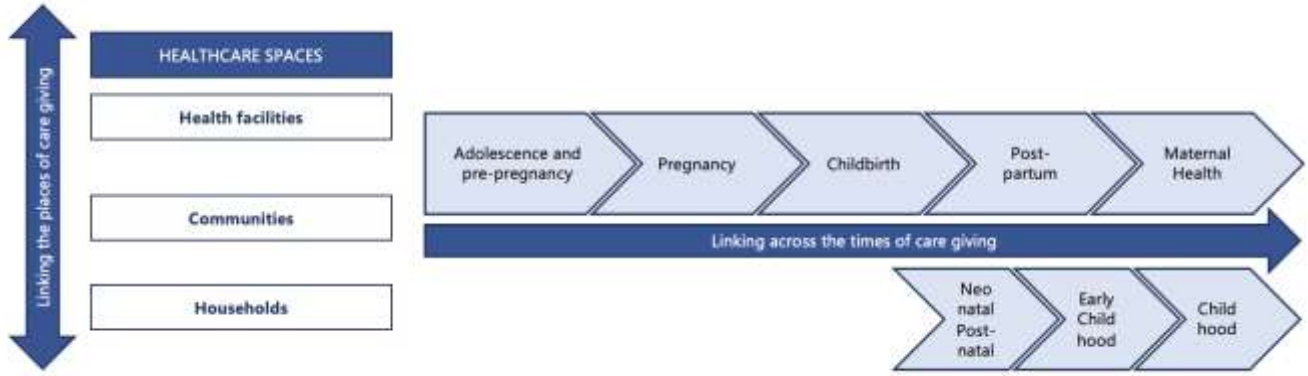


The Referral Coordinator team has already demonstrated impact and its ability to adapt to changing contexts. Future opportunities for the system include further analysis and utilisation of the rich data gathered and to more effectively collaborate with the Directorate of Policy, Planning, and Information to improve closer integration.

[133] Kings Global Health Partnerships. Impact Report. The right care at the right time. Building a national referral system in Sierra Leone.

[134] FCDO, USAID, World Bank and WHO

Appendix 15: Continuum of Care



The continuum of care for maternal, newborn and child health services (adapted from Kerber et al., 2007[135])

[135] Kerber et al. (2007). Counting every stillbirth and neonatal death through mortality audit to improve quality of care for every pregnant woman and her baby. BMC Pregnancy Childbirth. 15 Suppl 2.

Appendix 16: Detailed VfM Recommendation

A future programme could improve the ***measurement* of VfM** with these actions:

- Jointly develop a VfM framework for successor programme with IPs building on existing experience of tracking and reporting VfM
- Select indicators and analysis to meet FCDO requirements whilst at the same time providing data which is useful for IPs to improve VfM during implementation
- Consider areas that are under-reported within outputs as well areas such as technical assistance or other areas of activity such as support to NSBS and DHMTs.
- Examine ways in which to systematically capture work done in partnership or co-funded with funds leveraged from other donors.
- For areas that cannot be covered by VfM indicators, consider case-studies and the data that would be required during data collection for these case-studies.
- Align routine monitoring data with data for VfM analysis e.g., collection data on activities and reach for Equity (PWD, youth)
- Build in data requirements for VfM into contracts and MOUs with IPs so systems for data collection can be set up at the start of implementation

The ***management* of VfM** could be improved with these actions:

- Include training on VfM for field-level teams to develop their understanding of the principles and embed 'culture' of VfM – using resources in an optimal way to maximise impact
- Include MoHS counterparts in discussion on VfM to increase their understanding on the role of VfM and decisions made using VfM principles. Training for programme staff to embed culture of VfM could include admin staff in DHMTs.

Appendix 17: Overview of development partners operating in areas linked to SLiSL

UK policy priorities

A future programme should be grounded in the UK's global and country-specific policy and priorities. Sierra Leone is a priority for UK aid as seen in the HMG's renewed commitment to Africa in the new aid strategy (May 2022) and Sierra Leone is a focal country for the UK's commitment to ending preventable deaths in mothers, children, and new-borns.

Other development partners working in Sierra Leone

There are currently relatively few donors working in Sierra Leone, despite an influx of development partners and resources during the Ebola outbreak[136]. The table below shows the major donors and their areas of focus related to health.

Table 10: The main development partners in Sierra Leone, adapted from HEART Break Review: Saving Lives in Sierra Leone Programme Volume 1 page 18

Organisation	Type of partner and engagement	Areas of investment in health
AISPO	International NGO implementing international cooperation activities in the health sector.	AISPO, Italian Association for Solidarity Among People, is an NGO founded at the Scientific Institute San Raffaele Hospital of Milan. A significant focus of AISPO's work in Sierra Leone has been supporting access to safe blood and blood deliverables for patients in need of blood transfusions, particularly women in labour, newborns, and children with severe anaemia. They have also been involved in emergency hospital care for trauma and caustic soda ingestion in children. They are likely to be a major support going forwards.
BMGF	Global grant funding organisation	Areas of support include disease surveillance and supporting quality of care in Sierra Leone.
CHAMPS	International NGO focussed on research around child mortality	CHAMPS is a global surveillance network that generates and shares accurate cause of death data on child mortality. In Sierra Leone, CHAMPS works in Makeni, the largest city in the country's northern province and one of the hardest hit areas during the Ebola outbreak. Key partners in Sierra Leone include: Crown Agents, Focus 1000, World Hope International and MoHS. The CHAMPS network uses innovative approaches to generate and share knowledge and research that improves understanding and prevention of child mortality.
FCDO	Bilateral donor - UK	Sierra Leone is focal country for the UK's renewed manifesto commitment on ending preventable deaths of mothers, children, and new-borns. Projects include: Saving Lives in Sierra Leone programme for women and children and Wish2Action for family planning. Global health security programmes: Tackling Deadly Diseases in Africa programme, Fleming Fund tackling anti-microbial resistance.
GAVI	Global financing mechanism for access to new or underused vaccines	Vaccines include HPV pilot. Other support: community health workers to identify immunisation defaulters, support for MoHS technical staff, data quality audit, post graduate education for one specialist.
GIZ	Human resources for Health	Invests in strengthening the health care system including training and further education for health care staff. Promotion of cross-border epidemic control. Other sectors: employment promotion and agriculture.

[136] HEART, Allison Beattie, Heidi Jalloh-Vos. Break Review: Saving Lives in Sierra Leone Programme Vol. 1, March 2018

Organisation	Type of partner and engagement	Areas of investment in health
Global Fund	Global financing mechanisms to support AIDS, TB, and malaria	Grants support interventions for malaria and TB, health worker development at community level, strengthening HRH management systems, storage, and distribution of health commodities, HMIS, health laboratory network, capacity for disease control response of community organisations, evidence generation projects. Currently 60% of community health workers stipends are covered by the Global Fund alongside PMI and GAVI - the vaccine alliance. In May 2023, a new Global Fund bid for Sierra Leone was submitted for funds totalling 136 million US$ supporting interventions for malaria, TB, and HIV. The new bid includes 28 million US$ focussed on health systems strengthening and, if successful, will cover the period July 2024 – June 2027. Planned support (if granted) includes continued support to commodities storage and supply chain management.
Irish Aid	Bilateral donor – Ireland	Nutrition in young children, severe acute malnutrition (SAM) detection, and treatment, access to health care, life skills and psychosocial support for adolescent girls.
JICA	Bilateral donor – Japan	Health sector: flagship programme is Integrated Supportive Supervision project operational since 2013. Also worked with WB on universal health coverage. Plus, project for strengthening Children's hospital in Freetown.
Kings Global Health Partnerships, Kings College London	NGO called the Kings Sierra Leone Partnership (KSLP) in Sierra Leone	KSLP was established in 2013 and works to strengthen the health system in Sierra Leone with a focus on the following areas: • Health workforce development • Patient care and experience • Strengthening hospital management • Clinical innovation and best practice Kings delivered elements of SLiSL.
LAD	Large anonymous donor	A LAD supported antenatal, post-abortion and other care elements in reproductive health for WHO alongside support to postgraduate training in paediatrics and obstetrics and gynaecology
PMI	Bilateral – USAID programme	The US President's Malaria Initiative (PMI) is the US government's largest programme leading the fight against malaria. PHI run five World Bank districts and Kono (2023).
RCPCH	The Royal College of Paediatrics and Child Health is the membership body for paediatricians in the UK and around the world.	RCPCH works on child health programmes in Sierra Leone through local partners and MoHS. The focus of this work is on sharing and building expertise – that will advance the quality and scope of child health care. RCPCH delivered essential elements of SLISL e.g., Emergency Triage Assessment and Treatment
SIDA	Bilateral donor - Sweden	Areas of support in Sierra Leone include reproductive health.
Welbodi partnership	INGO	The partnership works to build the capacity of the health system in Sierra Leone, to reduce the number of women and children who are sick, suffer or die unnecessarily. Wellbodi focus on five key areas: i) neonatal health; ii) maternal health; iii) community health; iv) health systems strengthening and v) emergency response. They delivered elements of SLiSL.

Organisation	Type of partner and engagement	Areas of investment in health
World Bank	Development bank leading and granting funds to the GoSL, including health services support.	Health: Quality Essential Health Services and Systems Support Project. Other sectors include: Education, agriculture and business, resilience and disaster preparedness, sustainable growth. World Bank is delivering in 5 districts (2023)
WHO	UN health technical body and standard setting, evidence, and technical guidance	Support Information systems, health financing systems including the proposed national health insurance scheme, detection, tracking, and control of communicable diseases (health security agenda through Resilience Zero), IDSR, ETAT, MDSR support; direct support to health facilities and district health teams. Through secretariat function plays a role in coordination of development partners. Working with Ministry to strengthen its coordinating function137.
UNFPA	UN organisation supporting reproductive and maternal health in adults, youth, and adolescents	Family planning support and provision of all reproductive health commodities through the global supplies programme. Reducing teenage pregnancy, adolescent services, providing specialist doctors for maternal referral hospitals, training materials, and support to EmONC training, MDSR support, and the lead on supporting the national blood bank service, support to midwifery services.
UNICEF	UN organisation to support and protect children	Maternal, neonatal and child health. Nutrition. Education. Water Sanitation and Hygiene. Including: Newborn and specialised baby care units and doctors for neonatal emergency care/high care at referral hospitals; Community Health Workers, medicines procurement; information systems support; IPTi for infants; nutrition and Infant and Young Child Feeding (IYCF); HIV/syphilis testing of mothers; community engagement through village development committees and communication plan; WASH installations.
USAID/CDC	Bilateral – USAID programme is from the Guinea office, but CDC has an office in Freetown	Supporting SL's HIV response through U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Post Ebola response, focus is to strengthen laboratory, surveillance, emergency management, and workforce capacity to prevent and respond to disease outbreaks. USAID is delivering RMNCAH in 5 districts in 2023

Implications for future programmes

The development partners working in Sierra Leone have shared interests in strengthening the health sector, providing support in infectious and communicable diseases, and RMNCAH. While this creates the potential for a duplication of efforts, the relatively small numbers of donors also creates the opportunity for greater collaboration and coordination, agreement of priorities, and strategic, joined-up decision-making between development partners, led by Sierra Leone's MoHS.

[137] WHO Country Cooperation Strategy 2017 https://www.who.int/publications/i/item/WHO-CCU-18.02-SierraLeone